COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON THE

HEALTH OF THE COUNTY

FOR THE YEAR 1961

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B.,
M.R.C.S., L.R.C.P., D.P.H.,
County Medical Officer.

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HEALTH COMMITTEE, 31st DECEMBER, 1961

Chairman: Mr. R. F. Dickinson.

Vice-Chairman: Mrs. E. G. Cain, O.B.E.

Askew, J.
Bainbridge, J. J.
Barton, Dr. E. B.
Bland, T. P.
Curwen, Mrs. J. N. St. G.
Dickinson, D. L.
Dixon, W.
Herdman, J. F.
Johnston, T. W.
Kilbride, J.
McCann, Rev. F. K.
McKeating, Mrs. B. O.
McPoland, Mrs. F.
Nixon, W. G.
Perrott, Dr. E. A.
Smith, Mrs. M.
Stephenson, W.
Thomas, H.
Vane, Mrs. M. F.
Wilson, D. G.
Wilson, Mrs. M. A.

Ex-Officio Members:

Chairman of County Council—Westoll, J.

Vice-Chairman of County Council—Edmonds, C.

Chairman of Finance Committee—Highton, L.

External Members:

Collins, R. G.
Faulds, Dr. J. S.
Ferguson, Dr. T. T.
Fletcher, Dr. A. F.
Grant, Dr. R. N. R.
Hasell, Mrs. G., O.B.E.
Hodgson, Mrs. H. L.
James, Mrs. E. L.
Long, R.
Ritson, C.
Rolland, Dr. C.
Whiteley, Miss D. I.
Wood, Mrs. C. H.
Young, A.

PREFACE

To the Chairman and Members of the Cumberland County Council

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report for the year ended 31st December, 1961, which is prepared in accordance with Ministry of Health Circular 1/62.

The main event in the year has been the implementation of the decision of the County Council to incorporate the Welfare Section into the Health Department, following the retirement of Mr. W. C. Walker, M.B.E., County Welfare Officer. This is an event of great fundamental importance and during the year the integration of welfare and health matters has been my primary departmental consideration.

The Mental Health Act, 1959, has also caused much thought and action. The concept of the all-purpose Mental Welfare Officer with a particular area of the county to cover for community care and social support of all cases of mental disorder, and with responsibility for admissions to hospital, has taken shape in East Cumberland, and is shortly to do so in the remainder of the County.

During the year Dr. J. Braithwaite, Medical Superintendent of Garlands Hospital, retired after many years of valuable and devoted service, and his successor, Dr. W. G. A. Begg, was appointed.

The pilot scheme for the secondment of Health Visitors to groups of general practitioners has been so successful that groups of doctors in nearby areas have expressed a willingness to have such a secondment. By the end of the year arrangements were made for a total of 34 doctors (14 practices) to have seconded to them a total of 10 health visitors. The scheme ensures the best use of the health visitor's time, and her horizons as to the nature of general medical practice are broadened. Also I feel that family doctors are now more aware of the widening scope of the work of the health visitor—the nurse social worker.

Arrangements were made during the year for health visitors and district nurses to follow up the cases of patients discharged from hospital and I consider the arrangements to be quite satisfactory.

The chiropody scheme has been most successful. At the year end some 2,000 elderly persons were receiving treatment. I am greatly indebted to the voluntary bodies in various parts of the County for the smooth running of this scheme. This authority is also exceedingly fortunate in having the services of a full-time chiropodist, Mr. G. H. Thomas, whose work is the basis of an interesting item in the Report.

There has long been a need in this agricultural county for a system whereby a quick check on the tetanus immunity state of injured persons was possible, and in an effort to solve this problem arrangements were made during the year to let Casualty Surgeons in East and West Cumberland have a record card for all children who are known to the Department to have been vaccinated against tetanus. Thus the injured patient's state of protection can be ascertained from the newly established Hospital registers. The information contained in these registers is of course available to family doctors at any time.

During the year policy documents recommending a change from a contractual ambulance service to a direct service were accepted by the Council, and a three phase programme starting with a direct radio-controlled service in East Cumberland was arranged, to come into operation on the 1st June, 1962. The second phase will be centred on radio-control at Wigton, the last phase to be controlled from West Cumberland.

Arrangements for Health Education have continued during the year and with an increasing library of visual aids it has been possible for a wide variety of health education subjects to be taken up by the health visitors and school nurses in the child welfare clinics, the schools and at meetings of voluntary bodies.

The County of Cumberland has a very high peri-natal mortality rate, which is unfortunately not decreasing with the years, and is in an unfavourable position in this respect in relation to neighbouring counties and greatly inferior to southern counties. It is exceedingly hopeful that at last two Local Maternity Liaison Committees have been established in order to view objectively the factors influencing this figure, and by their advice and influence on the service as a whole, both hospital and domiciliary, to bring this rate, which is a sensitive index of the quality of obstetric care, to a lower and better figure than it has been in the past.

In an attempt to keep general practitioners in touch with activities of the County Health Department a bulletin is now issued periodically giving information of special interest.

Research plays a vital part in the work and progress of a

Health Department and during the year in association with a group of busy general practitioners, to whom I am very grateful, a Survey on the "Need of Chiropody amongst the Elderly" was carried out and the results recently analysed. The initial work on a "Child Welfare Clinics Survey" was commenced during the year, and I hope to be able to publish the results in next year's Report. I have also been co-operating with the Department of Social Medicine, Oxford University, in the extended Survey of Childhood Malignancies.

During the year four cases of poliomyelitis were notified. These are the first cases to be notified since 1958 and the need to continue the large scale poliomyelitis vaccination programme must be stressed. Tuberculosis notifications continue their downward trend and I am happy to state that there have been no diphtheria notifications since 1951.

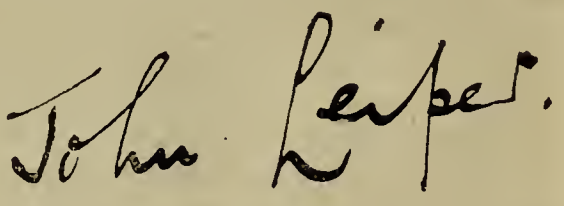
A great deal of time during the year has been taken up attending various meetings, especially those with the departmental staff, and trying to integrate and streamline their efforts both in the field and with regard to associated clerical work. The meetings include bi-monthly meetings of Assistant County Medical Officers, quarterly meetings of District Nurses, Domiciliary Midwives, Health Visitors, Mental Welfare Officers and Speech Therapists.

During the year Mr. A. C. S. Martin, Chief Dental Officer, retired after 24 years service in Cumberland, and Mr. R. B. Neal was appointed to the post.

My thanks are due to the members of the Council, especially the Chairman of the Health Committee, to my brother officers of the Council, to the Cumberland Council of Social Service and all the voluntary organisations.

The work of all members of the Health Department has continued to be invaluable and of the highest standard.

I am, Ladies and Gentlemen,
Your obedient Servant,



County Medical Officer.

County Health Department,
11 Portland Square,
Carlisle.
May, 1962.

Telephone No.: Carlisle 23456

MEDICAL, DENTAL AND ANCILLARY STAFF

County Medical Officer and Principal School Medical Officer—

J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

Deputy County Medical Officer and Deputy Principal School Medical Officer—

J. D. Terrell M.B., Ch.B., D.P.H., D.C.H.

Assistant County and School Medical Officers, and District Medical Officers of Health—

J. L. Hunter, M.B., Ch.B., D.P.H., Senior Assistant County Medical Officer and Medical Officer of Health, Workington Borough.

J. N. Dobson, M.B., Ch.B., D.P.H., Medical Officer of Health, Whitehaven Borough and Ennerdale Rural District.

J. R. Hassan, M.B., Ch.B., D.R.C.O.G., Medical Officer of Health, Alston Rural District (also general practitioner).

T. F. M. Jackson, L.R.C.P., L.R.C.S., L.R.F.P.S., D.P.H., Medical Officer of Health, Millom Rural District.

I. S. Jones, M.R.C.S., L.R.C.P., D.P.H., Medical Officer of Health, Wigton Rural District and Penrith Urban District (resigned 30.4.61).

J. Patterson, M.B., B.Ch., B.A.O., D.P.H., Medical Officer of Health, Cockermouth Rural and Urban Districts and Keswick Urban District.

H. C. T. Smith, M.B., Ch.B., D.P.H., D.P.A., Medical Officer of Health, Wigton Rural District and Penrith Urban District (commenced 1.5.61).

K. J. Thomson, M.B., Ch.B., D.P.H., Medical Officer of Health, Border Rural District and Penrith Rural District.

Assistant County and School Medical Officers—

G. G. W. Bennet, M.B., Ch.B., D.P.H. (resigned 12.11.61).
E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. & H.
A. B. C. Halliday, M.B., Ch.B. (commenced 13.11.61).
C. H. Mair, L.R.C.P., L.R.C.S. (Ed.), D.P.H.
E. M. Spencer, M.B., Ch.B. (commenced 1.2.61).

Chief Dental Officer—

A. C. S. Martin, L.D.S. (resigned 31.8.61).
R. B. Neal, M.B.E., L.D.S., R.C.S. (commenced 1.9.61).

Dental Officers—

I. R. C. Crabb, L.D.S.
D. H. Hayes, L.D.S.
M. Hayes, B.D.S.
F. H. Jacobs, L.D.S.
A. MacDonald, L.D.S.
A. R. Peck, L.D.S.
J. G. Potter, L.D.S.
A. M. Scott, L.D.S.
J. Watson, B.D.S., L.D.S.

Welfare Services Officer—

S. Hodgson, F.C.C.S.

Mental Health—

Consultant Psychiatrists (Part-time) seconded from Newcastle-upon-Tyne Regional Hospital Board—

J. R. Stuart, M.B., Ch.B., D.P.M.
T. T. Ferguson, L.R.C.P., L.R.C.S., L.R.F.P.S.

Mental Health Officer—

N. Froggatt.

Senior Mental Welfare Officer—

Mr. E. L. Mayoh (commenced 12.9.61).

Mental Welfare Officers—

Mr. J. A. Denton (commenced 1.5.61).
Miss E. F. Hall.
Mr. J. Nicholson (commenced 1.5.61; resigned 4.11.61).
Mr. M. H. Payne.
Miss E. Welch.

Psychiatric Social Workers—

Miss M. Lamb (part-time).
Mr. R. Milne (resigned 31.7.61).

Nursing Staff—

Superintendent Nursing Officer—
Miss I. Mansbridge, S.R.N., S.C.M., Q.N., H.V.Cert.

Deputy Superintendent Nursing Officer—
Miss M. Blockey, S.R.N., S.C.M., Q.N., H.V.Cert.

Assistant Superintendent Nursing Officers—
Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V.Cert.
Miss P. G. O'Sullivan, S.R.N., S.C.M., Q.N., H.V.Cert., P.H.Admin.Cert.
Miss D. D. James, S.R.N., S.C.M., Q.N., H.V.Cert., (temporary to 3.7.61).

Health Visitor for Health Education—
Miss G. L. Benfield, S.R.N., S.C.M., H.V.Cert., P.H.Admin.Cert. (resigned 10.9.61).

Health Visitors	...	23	whole-time	1	part-time		
District Nurse Midwives/ Health Visitors	...	38	„ „	1	„	„	
District Nurse/Midwives	...	19	„ „	1	„	„	
Midwives	...	7	„ „	—	„	„	
District Nurses	...	11	„ „	6	„	„	
School and Clinic Nurses	...	4	„ „	2	„	„	

Orthopaedic Physiotherapists—
Miss J. M. Morris, M.C.S.P., M.E.
Miss J. A. Fraser, M.C.S.P., O.N.C.

Orthoptist—
Miss J. Modlin, D.B.O. (commenced 3.1.61))

Speech Therapists—
Miss C. M. Allan, L.C.S.T. (commenced 4.9.61).
Mrs. S. E. Latimer, L.C.S.T.(Part-time — resigned 31.5.61).
Miss E. B. Moon, L.C.S.T.
Miss E. M. Rawle, L.C.S.T.
Mrs. A. Taylor, L.C.S.T. (Part-time — resigned 12.5.61).

Senior Administrative Assistant—
J. J. Pattinson, D.F.C.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County—967,054 acres.

Rateable Value (April 1st, 1961)—£2,285,206.

Estimated product of 1d. rate (1961-62)—£9,002.

Population (Census, 1951)—217,540.

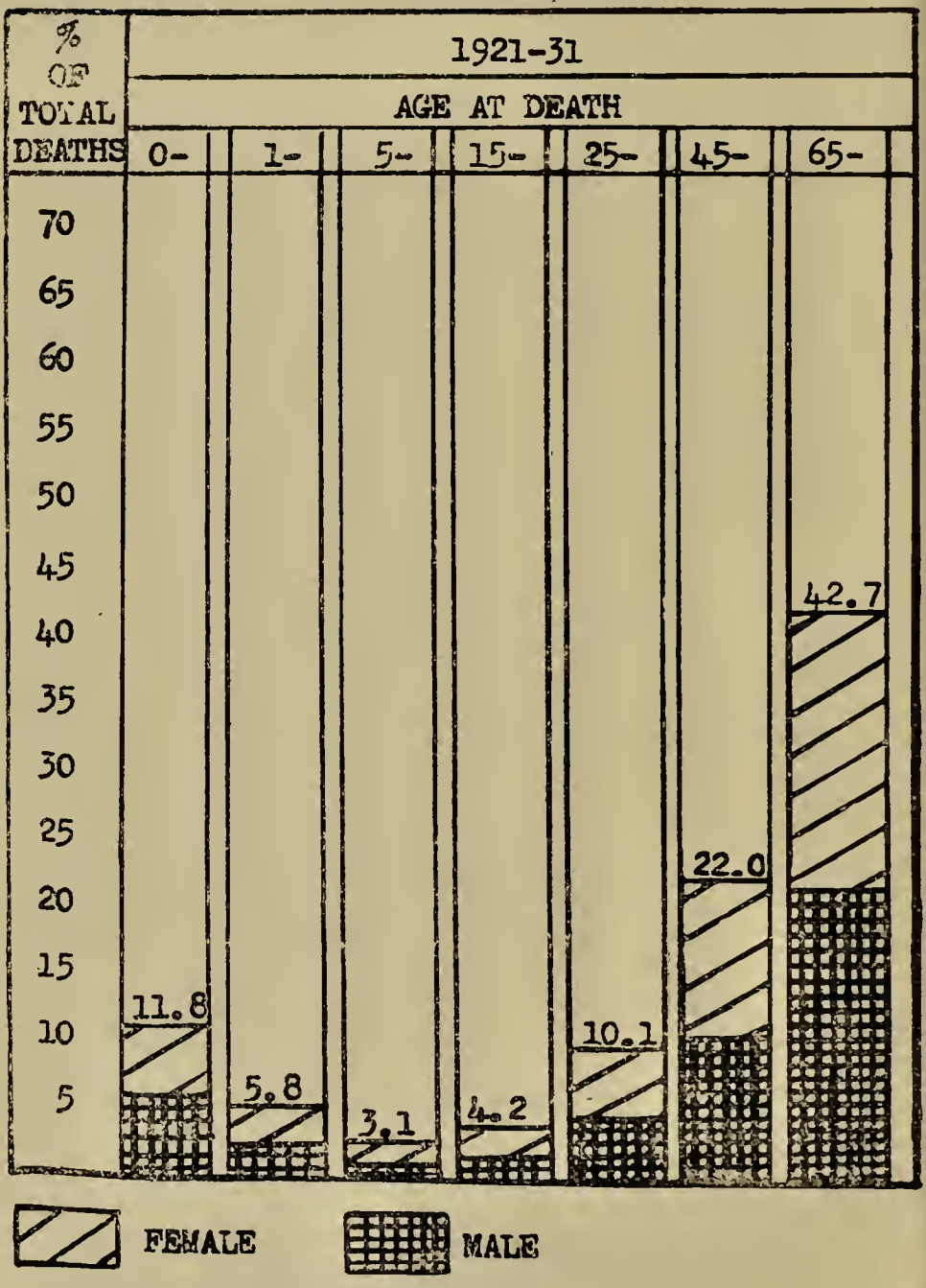
Population (Census, 1961)—223,050.

Population (1961 Mid-year estimate)—221,460.

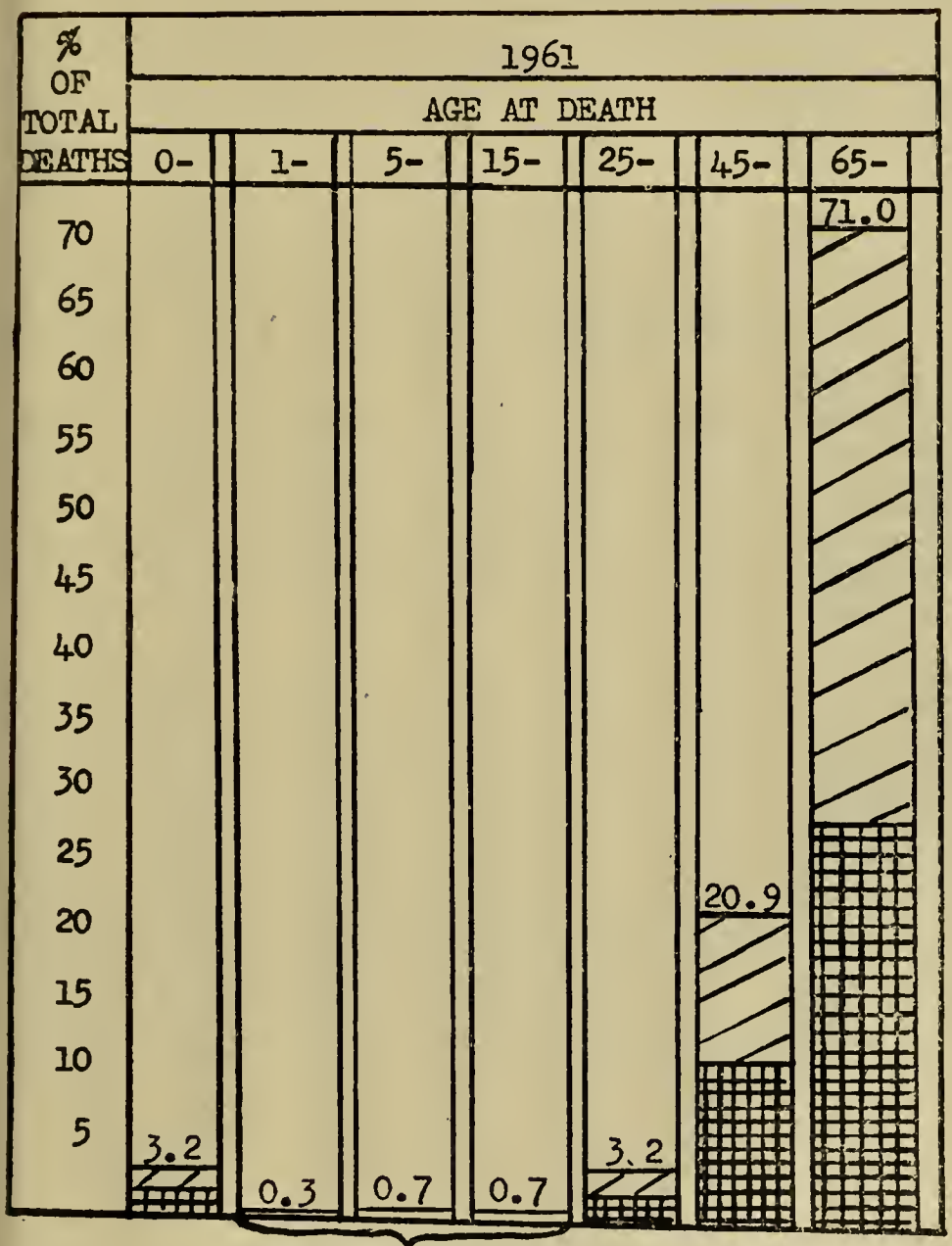
Live Births—Number	3,900
Rate per 1,000 population	17.6
Illegitimate live births per cent. of total live births	3.9%
Still Births—Number	76
Rate per 1,000 total live and still births	19.1
Total live and still births	3,976
Infant deaths (deaths under 1 year)	88
Infant mortality rates—	
Total infant deaths per 1,000 total live births	22.6
Legitimate infant deaths per 1,000 total legitimate births	21.6
Illegitimate infant deaths per 1,000 total illegitimate births	46.4
Neo-natal mortality rate (deaths under 4 weeks per 1,000 total live births)	18.2
Early neo-natal mortality rate (deaths under 1 week per 1,000 total live births)	13.6
Perinatal mortality rate (Still births and deaths under 1 week combined per 1,000 total live and still births)	32.4
Maternal mortality (including abortion)	Nil
Rate per 1,000 total live and still births	—

A more detailed analysis of the above figures is given overleaf:

	Male.	Female.	Total.	Urban Districts.	Rural Districts.	Admin. County.	Eng'd and Wales. (prov.)
LIVE BIRTHS—							
Legitimate ...	1930	1819	3749				
Illegitimate ...	83	68	151				
	2013	1887	3900				
Birth rate per 1,000 population ...				17.8	17.5	17.6	17.4
STILL BIRTHS—							
Legitimate ...	29	43	72				
Illegitimate ...	—	4	4				
	29	47	76				
Still birth-rate per 1,000 total births ...				14.7	22.1	19.1	18.7
DEATHS—							
All causes ...	1325	1400	2725				
Death rate per 1,000 population ...				12.6	12.1	12.3	12.0
INFANT DEATHS—							
All infants under 1 year of age—							
Legitimate ...	52	29	81				
Illegitimate ...	5	2	7				
	57	31	88				
Total infant deaths per 1,000 total live births				22.4	22.6	22.6	21.4


% OF TOTAL DEATHS
1921-31
AGE AT DEATH
0-
1-
5-
15-
25-
45-
65-
70
65
60
55
50
45
40
35
30
25
20
15
10
5
11.8
5.8
3.1
4.2
10.1
22.0
42.7
FEMALE
MALE

CUMBERLAND 1921-31 to 1961



District	BIRTHS				
	Legitimate	Illegitimate	Total	Births per 1,000 of population (crude)	Comparability factor
URBAN DISTRICTS—					
Cockermouth ...	101	2	103	17.7	0.99
Keswick ...	67	5	72	15.5	1.00
Maryport ...	196	11	207	16.8	0.95
Penrith ...	169	4	173	16.1	1.01
Whitehaven ...	515	22	537	19.7	0.96
Workington ...	488	24	512	17.4	0.97
Aggregate ...	1536	68	1604	17.8	0.97
RURAL DISTRICTS—					
Alston ...	28	—	28	12.8	1.09
Border ...	436	19	455	15.4	1.15
Cockermouth ...	319	8	327	16.2	0.99
Ennerdale ...	613	28	641	20.6	1.01
Millom ...	277	6	283	18.8	1.02
Penrith ...	190	5	195	17.2	1.03
Wigton ...	350	17	367	16.7	1.02
Aggregate ...	2213	63	2296	17.5	1.04
Administrative County ...	3749	151	3900	17.6	1.01

AND POPULATION IN THE YEAR 1961

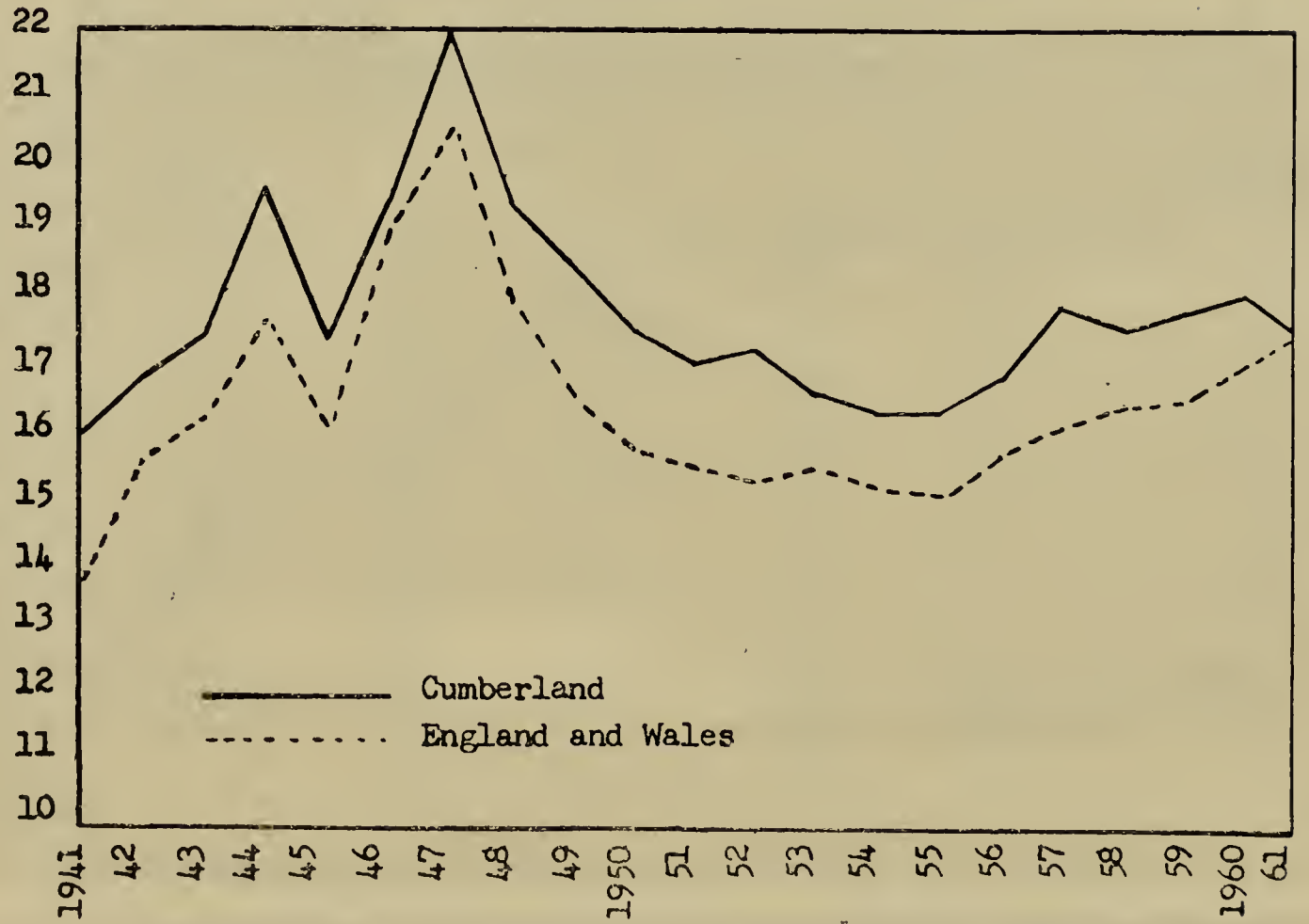
DEATHS			INFANT MORTALITY				
Total Deaths	Deaths per 1,000 of population (crude)	Comparability factor	Legitimate	Illegitimate	Total	Deaths of Infants under 1 year per 1,000 live births	Estimated mid-year population
63	10.8	1.05	2	—	2	19.4	5810
86	18.5	0.86	2	—	2	27.8	4640
164	13.3	1.14	5	—	5	24.2	12340
152	14.1	0.93	4	—	4	23.1	10760
322	11.8	1.16	12	2	14	26.1	27290
349	11.8	1.18	9	—	9	17.6	29490
1136	12.6	1.10	34	2	36	22.4	90330
44	20.2	0.94	2	—	2	71.4	2180
395	13.4	0.98	9	—	9	19.8	29480
216	10.7	1.08	4	—	4	12.2	20150
346	11.1	1.21	15	4	19	29.6	31060
148	9.8	1.13	4	—	4	14.1	15030
129	11.4	1.00	2	—	2	10.3	11310
311	14.2	1.01	11	1	12	32.7	21920
1589	12.1	1.06	47	5	52	22.6	131130
2725	12.3	1.09	81	7	88	22.6	221460

BIRTH AND DEATH STATISTICS

Year	Estimated Mid-Year Population	Births		Deaths		Excess of Births over Deaths
		No.	Rate	No.	Rate	
1921 ...	216691	5325	24.5	2703	12.5	2622
1931 ...	205270	3589	17.4	2813	13.7	776
1938 ...	194900	3092	15.9	2638	13.0	454
1951 ...	214700	3681	17.1	2827	13.2	854
1952 ...	215050	3714	17.3	2603	12.1	1111
1953 ...	216100	3608	16.7	2571	11.9	1037
1954 ...	216600	3533	16.4	2567	11.9	966
1955 ...	216700	3556	16.4	2653	12.2	903
1956 ...	217450	3679	16.9	2653	12.2	1026
1957 ...	217600	3901	17.9	2640	12.1	1261
1958 ...	217700	3834	17.6	2643	12.1	1191
1959 ...	218900	3888	17.8	2611	11.9	1277
1960 ...	219160	3940	18.0	2629	12.0	1311
1961 ...	221460	3900	17.6	2725	12.3	1175

COMPARISON OF DEATHS OF INFANTS UNDER ONE YEAR, 1941 to 1961

COMPARISON OF BIRTH RATES, 1941 to 1961



COMPARISON OF DEATH RATES, 1941 to 1961

	Cause of Death	Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.	Penrith U.D.
	All Causes	2725	63	86	164	152
1.	Tuberculosis, Respiratory	8	—	—	2	—
2.	Tuberculosis, other	1	—	—	—	—
3.	Syphilitic disease	3	—	—	—	—
4.	Diphtheria	—	—	—	—	—
5.	Whooping cough	—	—	—	—	—
6.	Meningococcal infections	—	—	—	—	—
7.	Acute Poliomyelitis	—	—	—	—	—
8.	Measles	—	—	—	—	—
9.	Other infective and Parasitic diseases ...	6	—	—	1	—
10.	Malignant neoplasm, stomach	73	2	3	6	3
11.	Malignant neoplasm, lung bronchus ...	49	1	1	3	3
12.	Malignant neoplasm, breast	37	1	—	1	2
13.	Malignant neoplasm, uterus	19	—	—	1	1
14.	Other malignant and lymphatic neoplasms	207	3	12	11	15
15.	Leukaemia, Aleukaemia	17	—	1	—	3
16.	Diabetes	21	3	—	1	—
17.	Vascular Lesions of Nervous System ...	451	7	13	29	30
18.	Coronary Disease, Angina	516	16	18	34	25
19.	Hypertension with Heart Disease ...	57	2	1	2	1
20.	Other Heart Disease	409	7	17	24	30
21.	Other Circulatory Disease	128	5	1	10	8
22.	Influenza	30	2	3	—	—
23.	Pneumonia	92	—	1	2	5
24.	Bronchitis	100	1	—	9	8
25.	Other Disease of the Respiratory System	28	1	3	—	—
26.	Ulcer of Stomach and Duodenum ...	18	2	—	—	1
27.	Gastritis, Enteritis and Diarrhoea ...	12	—	—	1	—
28.	Nephritis and Nephrosis	16	—	1	1	1
29.	Hyperplasia of Prostate	11	—	1	4	1
30.	Pregnancy, Childbirth and Abortion ...	—	—	—	—	—
31.	Congenital Malformations	21	1	—	1	—
32.	Other Defined and Ill defined diseases ...	268	6	8	14	8
33.	Motor vehicle accidents	41	3	1	—	3
34.	All other accidents	65	—	—	6	3
35.	Suicide	19	—	1	1	1
36.	Homicide and Operations of War ...	2	—	—	—	—

DMINISTRATIVE AREAS (1961)

Whitehaven M.B.	Workington M.B.	Aggregate of U.D.'s	Alston R.D.	Border R.D.	Cockermouth R.D.	Ennerdale R.D.	Millom R.D.	Penrith R.D.	Wigton R.D.	Aggregate of R.D.'s
322	349	1136	44	395	216	346	148	129	311	1589
2	1	5	—	2	—	1	—	—	—	3
—	—	—	—	—	—	1	—	—	—	1
—	—	—	—	—	—	—	—	1	2	3
—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—
—	1	2	—	1	—	1	—	2	—	4
7	7	28	—	8	5	10	4	4	14	45
8	6	22	1	9	1	7	2	1	6	27
3	6	13	—	3	3	7	3	4	4	24
3	5	10	1	2	1	1	2	1	1	9
25	32	98	4	25	18	24	11	7	20	109
—	2	6	—	3	1	3	—	2	2	11
4	2	10	—	5	1	3	—	—	2	11
41	62	182	16	60	36	63	22	25	47	269
45	75	213	8	56	52	62	42	18	65	303
11	6	23	—	10	4	6	3	3	8	34
41	38	157	5	93	32	30	14	30	48	252
15	15	54	—	17	11	25	5	4	12	74
—	3	8	1	5	1	3	1	3	8	22
7	12	27	2	21	9	14	8	—	11	65
12	20	50	1	10	9	14	6	3	7	50
5	2	11	—	1	1	9	1	1	4	17
1	3	7	1	3	4	1	1	—	1	11
—	1	2	—	3	2	2	1	—	2	10
1	1	5	—	2	3	—	2	1	3	11
2	1	9	—	—	—	—	—	—	2	2
—	—	—	—	—	—	—	—	—	—	—
4	5	11	—	2	2	4	—	1	1	10
69	28	133	2	30	15	39	13	9	27	135
6	4	17	1	11	1	4	2	3	2	24
9	6	24	—	9	4	11	5	4	8	41
—	5	8	1	3	—	1	—	2	4	11
1	—	1	—	1	—	—	—	—	—	1

SECTION 22

CARE OF MOTHERS AND YOUNG CHILDREN

Perinatal Mortality

The perinatal mortality rate — the number of stillbirths and infant deaths under the age of seven days — is now well established as the most significant single mortality rate affecting childhood. The causes of stillbirths and of deaths under one week have a great deal in common and I have combined the record of both rates for the past ten years in a single table shown below, together with national rates for comparison.

A recent comparison of the perinatal mortality rates of counties in England and Wales between 1953 and 1958 showed Cumberland to have one of the highest rates and, what was more disturbing, not to be improving. Actually in 1959 Cumberland's rate (34.5) approximated closely to the overall figure for England and Wales (34.2), but last year's figure (42.2) was very disappointing and was associated with an unusually high number of stillbirths. I am glad to be able to report that hte figure for 1961 is 32.4. I hope that it will be shown in due course that the peak in 1960 was an isolated one in the graph of perinatal mortality in Cumberland.

The causes of perinatal death which figured most prominently in last year's report, viz., antepartum haemorrhage, difficulties associated with the Rh. factor and umbilical cord difficulties causing asphyxia, all show a welcome reduction for 1961, while there is an increase in the number of deaths due to congenital malformations.

Year	Stillbirths	Early Neonatal Deaths	Perinatal Deaths	Stillbirths per 1,000 total births		Perinatal Deaths per 1,000 total births	
				Cumberland	E'land & Wales	Cumberland	E'land & Wales
1951 ...	101	56	157	26.7	23.0	41.5	38.1
1952 ...	94	55	149	25.0	22.7	39.1	37.5
1953 ...	99	54	153	27.0	22.4	41.3	37.0
1954 ...	106	53	159	29.8	23.5	43.7	38.1
1955 ...	79	61	140	21.7	23.2	38.5	37.6
1956 ...	111	64	175	29.3	23.0	46.2	36.8
1957 ...	102	64	166	25.5	22.4	41.5	36.2
1958 ...	80	69	149	20.4	21.6	38.1	35.1
1959 ...	83	54	137	20.9	20.7	34.5	34.2
1960 ...	111	60	171	27.4	19.7	42.2	32.9
1961 ...	76	53	129	19.3	18.7	32.4	—

Analysis of Causes of 129 Perinatal Deaths during 1961

Cause of Death	Stillbirths		Deaths during	
	Premature	Full-time	1st week	Total
Toxaemia ...	2	1	1	4
Antepartum Haemorrhage ...	1	3	2	6
Placental Insufficiency (infarct.) ...	2	4	1	7
Rh. with Antibodies ...	1	1	4	6
Prematurity ...	—	—	10	10
Congenital Malformation ...	22	8	5	35
Maceration of Foetus ...	2	—	—	2
Postmaturity ...	—	3	1	4
Asphyxia—				
(1) Prolapse of Cord ...	—	3	—	3
(2) Cord round neck ...	2	—	—	2
(3) Uterine inertia ...	—	1	—	1
Difficult labour with breech delivery ...	2	—	1	3
Birth injury (Subtentorial haemorrhage ...	1	4	4	9
Intestinal obstruction and infection ...	—	—	1	1
Atalectasis ...	—	—	16	16
Pneumonia ...	—	—	6	6
Congenital heart disease ...	—	—	1	1
Vitamin K deficiency ...	—	1	—	1
Intrauterine anoxia ...	5	3	—	8
No known cause ...	1	3	—	4
	41	35	53	129

Infant Mortality

The following table shows the causes of deaths of infants under one year at different age periods. A high incidence of deaths in the first week due to atalectasis continues to be noticeable:—

Cause of Death	Age in Weeks 1	2—4	5—52	Total
Maternal toxaemia ...	1	—	—	1
Antepartum Haemorrhage ...	2	—	—	2
Placental Insufficiency ...	1	—	—	1
Rh. with Antibodies ...	4	1	—	5
Prematurity ...	10	—	—	10
Congenital Malformation ...	5	11	4	20
Postmaturity ...	1	—	—	1
Asphyxia due to inhalation of vomit ...	—	1	7	8
Difficult labour with breech delivery ...	1	—	—	1
Birth injury ...	4	—	—	4
Intestinal obstruction and infection ...	1	1	—	2
Atalectasis ...	16	1	—	17
Pneumonia ...	6	2	4	12
Congenital heart disease ...	1	1	—	2
Leukaemia ...	—	—	1	1
Hypothermia ...	—	—	1	1
	53	18	17	88

The number of infant deaths during the period 1921 to date with comparative rates per 1000 total live births for Cumberland together with England and Wales are as follows:—

Year	No. of Deaths under 1 year	Rate per 1000 total live births Cumberland	England & Wales
1921 ...	437	82	83
1931 ...	261	72	66
1951 ...	124	34	29.7
1952 ...	119	32	27.6
1953 ...	97	27	26.8
1954 ...	98	27.6	25.4
1955 ...	101	28.4	24.9
1956 ...	112	30.4	23.7
1957 ...	103	26.4	23.1
1958 ...	108	28.2	22.5
1959 ...	82	21.1	22.2
1960 ...	91	23.1	21.7
1961 ...	88	22.6	21.4

Prematurity

The survival rate of premature infants according to weight, place of birth and after-care is set out in the following table.

Of the 31 premature infants born at home and nursed entirely at home all survived 28 days, and it is interesting to note that of the 253 total number of premature infants born 36 died, but in 1960, 35 died out of a total of 238, which shows an improvement in the survival of these small babies.

During the year two new portable incubators were provided in the area and this Authority contributed a proportion towards the cost. These are the latest models incorporating control of temperature, humidity and oxygen concentration. It is considered that such a carrier is specially indispensable for the transporation of premature infants for long distances. An experienced midwife is always available at the appropriate maternity hospitals to accompany and control the equipment.

Premature Live Births

Weight at Birth.	Born in Hospital.*			Born at home and nursed entirely at home.			Born at home and transferred to hospital on or before 28th day.			PREMATURE STILL-BIRTHS.		
	Total.	Died within 24 hours of birth.	Survived 28 days.	Total.	Died within 24 hours of birth.	Survived 28 days.	Total.	Died within 24 hours of birth.	Survived 28 days.	Born in hospital.	Born at home.	Born in nursing home
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
(a) 3 lb. 4 oz. or less (1500 gms. or less) ...	26	13	9	—	—	—	3	1	2	17	2	—
(b) Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. (1500-2000 gms.) ...	33	3	27	1	—	1	3	1	2	10	1	—
(c) Over 4 lb. 6 ozs. up 4 lb. 15 oz. (2000-2250 gms.) ...	55	2	49	7	—	7	2	1	1	7	—	—
(d) Over 4 lb. 15 oz. up to and including 5 lb. 8 oz. (2250-2500 gms.) ...	96	2	93	23	—	23	4	—	3	2	2	—
TOTALS ...	210	20	178	31	—	31	12	3	8	36	5	—

* The group under this heading includes cases born in one hospital and transferred to another.

Unmarried Mothers

The arrangements for the care of unmarried mothers made in association with the Carlisle Diocesan Council for Social and Moral Welfare and the Lancaster Diocesan Protection and Rescue Society, continued to operate.

During the year, 35 cases were approved for maintenance at Coledale Hall, Carlisle; St. Monica's and Brettargh Holt at Kendal; and the Salvation Army Home, "Hopedene", Newcastle. The average length of stay after confinement at Coledale Hall was 15 days and at the other establishments it was 42 days.

The age groups of the 35 cases are shown in the following table together with comparable figures for the previous years, from which it will be seen that the year 1961 shows a decrease on the previous year.

Age	1961	1960	1959	1958	1957
13	—	1	—	—	—
14	—	—	—	—	1
15	1	1	1	—	—
16	3	3	3	1	1
17	5	3	4	2	3
18	2	3	6	5	5
19—24	22	20	16	15	15
25—30	1	10	5	5	9
31 and over	1	3	2	—	4
Totals	35	44	37	28	38

Distribution of Welfare Foods

Two changes occurred during 1961 in this service.

From the 1st June, 1961, the Ministry authorised increases in the prices of Orange Juice, bringing the price to 1s. 6d. per bottle as against the previous price of 5d., and at the same time Cod Liver Oil and Vitamin Tablets which had previously been free issues were to be charged at 1s. and 6d. respectively. There is no doubt that the introduction of the increased prices was reflected in a considerable decrease in the up-take of these items. The price of National Dried Milk remained the same throughout the year, but demand continued to decrease.

The second change which occurred during 1961 concerned the administrative arrangements whereby cash is now tendered for purchase instead of postage stamps as was the previous practice.

During the year 6 distribution points were closed, mainly in the rural areas, at Low Hesket, Raughton Head, Fletchertown, Rosley, Blindcrake and Netherton, Maryport.

Total issues to beneficiaries and hospitals

	National Dried Milk	Cod Liver Oil	Vitamin Tablets	Orange Juice
1955	... 145696	25082	6413	113548
1956	... 151101	23669	7274	124212
1957	... 128219	22517	6920	137336
1958	... 115685	15198	6338	89366
1959	... 105984	15350	7076	93684
1960	... 92676	14961	7450	90343
1961	... 78155	9067	5017	50653

Dental Services

The Chief Dental Officer makes the following comments on the dental services for 1961:—

In this my first, report on the dental treatment of maternity and child welfare patients, I would like to record my sincere appreciation to Mr. A. C. S. Martin, Chief Dental Officer for Cumberland, who retired in August, 1961, for all he did to impress upon the general medical practitioners and midwives the importance of ante and post-natal dental care, together with the examination and treatment of pre-school children.

It is encouraging to see that there has been a slight increase in the number of expectant and nursing mothers made dentally fit during 1961, the actual number being 48, and 27 more children under five years old were made dentally fit than in the previous year. Unfortunately, there are still many people who, although they are eligible for treatment in the County clinics, do not know of the facilities and have not been told by their own doctor nor, I am sorry to say, by the midwives or nurses. If only the British people were more tooth conscious and would attend for regular examination instead of waiting until they are driven to seek advice because of pain, a large percentage of the population would have the undoubted benefit of their own teeth until old age.

Health education is making some progress as regards teaching those people who want to learn, but we will have to devise some means whereby those who will not make the effort to attend talks or demonstrations can be instructed. Our Health Visitors are doing noble work in this sphere and I am grateful to them for their assistance.

One method by which it has been shown that dental caries can be reduced, is the fluoridation of water supplies. It involves no effort on the part of parent or child and one of our main problems to-day is to overcome the marked apathy shown towards conservative dental surgery. The amount of fluoride which is necessary to produce the desired effect is already present as a natural occurrence in the water supplies in some places. In Cumberland there is practically no fluoride in the water in any part of the county. The addition to a water supply of the required amount does not affect its taste in any way nor does it alter its hardiness so that its presence is undetectable in the ordinary way. I think

the import of these facts should be recognised by all who have a responsibility in the battle against dental decay, particularly in children.

In conclusion may I make a special plea for all young children to be taken to the dentist when their parents go, either for a routine examination or for actual treatment (with the exception of extractions under general anaesthesia) so that the child may become familiar at an early age with both the dentist and the surgery and " the fear of the unknown " will not be a problem when the child itself requires dental treatment.

Dental Care of Expectant and Nursing Mothers and Children under School Age

(a)	Number of Officers employed at end of year on a salary basis in terms of whole-time officers to the maternity and child welfare service :—	
	(1) Senior Dental Officer	.0563
	(2) Dental Officers	.563
(b)	Number of Officers employed at end of year on a sessional basis in terms of whole-time officers to the maternity and child welfare service	—
(c)	Number of dental clinics in operation at end of year	19
(d)	Total number of sessions (i.e. equivalent complete half days) devoted to maternity and child welfare patients during the year	210
(e)	Number of dental technicians employed in the Local Health Authority's own laboratories at the end of the year	2

Dental Treatment Return

Numbers provided with dental care :

(1)	Examined (2)	Needing treatment (3)	Treated (4)	Made Dentally fit (5)
Expectant and				
Nursing Mothers ...	389	386	371	251
Children under 5 ...	517	427	397	254

Forms of Dental Treatment provided :

(1)	Scalings and gum treatment. (2)	Fillings (3)	Silver Nitrate treatment. (4)	Crowns or Inlays. (5)	Extractions. (6)	General Anaesthetics. (7)	Dentures Provided. Full Upper or Lower (8)	Dentures Provided. Partial Upper or Lower (9)	Radiographs. (10)
Expectant and Nursing Mothers ...	25	305	—	6	1758	159	291	92	24
Children under 5 ...	16	147	57	—	856	279	—	—	5

Attendances at Child Welfare Centres

During the year there was a welcome increase in both the number of children who attended the child welfare centres and the number of attendances made.

Arrangements were established for the provision of a child welfare clinic in the village hall at Houghton.

The following table shows the number of centres provided together with details of children attending and the total attendances made:—

Year	No. of centres provided at end of year	No. of child welfare sessions held per month at centre	No. of children who first attended the centre during the year and who at their first attendance were under 1 year of age	No. of children attending during the year and who were aged			Total No. of children who attended during the year	Total attendances during the year
				Under 1 year	1—2 years	2—5 years		
1954 ...	15	65	1347	933	1027	1181	3141	12794
1955 ...	15	58	1382	975	896	1103	1947	11734
1956 ...	15	59	1458	1053	922	964	2939	11912
1957 ...	18	69	1754	1310	1051	1056	3417	14452
1958 ...	19	88	1757	1326	1192	1225	3743	18061
1959 ...	22	92	2093	1596	1455	1389	4440	21947
1960 ...	22	95	2011	1548	1408	1368	4299	22089
1961 ...	23	95	2373	1603	1667	1704	4974	23004

County Council Clinics

The need for the establishment of small clinics away from the main centres of population is becoming more evident. In some instances the provision of a maternity and child welfare clinic in a rented village hall meets the need, in others the provision of a purpose designed building must be considered.

During the year a clinic was commenced at Houghton and the attendances at this clinic are most encouraging. This clinic is held once a fortnight in the village hall.

At Seascale the provision of a clinic on similar lines has been in operation for a few years, but it is realised that the area needs now and in the future a permanent building. At the time of writing this report tenders were being sought for the erection of a clinic at Seascale. This building has been planned to accommodate not only a clinic but also a County Branch Library and is evidence of a joint planning arrangement. The clinic premises have been so designed that many different health services can be provided from the one building, this is possible because the lay-out of the clinic has been planned around one large multipurpose room.

Family Planning

The arrangements for advice on this subject have continued as in previous years. The Family Planning Association hold their clinics in the County Council premises at Park Lane, Workington, and Brunswick Square, Penrith. At Penrith arrangements can be made, which must be by appointment only, for sub-fertility advice. County patients who live near to Carlisle can be seen by appointment at Victoria Place, Carlisle.

Nurseries and Child Minders Regulation Act, 1948

During the year an application to be registered as a child minder was received from a lady at Brampton and this has been granted. There are now in the county three establishments registered and approved by the authority under this Act, providing altogether places for 29 children.

SECTION 23

MIDWIFERY SERVICE

During the year 146 midwives notified their intention to practice. These included 8 whole-time district midwives, 72 district nurse midwives working in urban and rural areas, and 62 midwives working in the maternity department of hospitals in the administrative county.

Part II training arrangements with Workington Infirmary continued to function very satisfactorily, and during the year 12 pupils completed their district experience with the Council's full-time midwives at Whitehaven and Cleator Moor. All pupils have been successful in passing the Part II examination of the Central Midwives Board.

The number of domiciliary confinements undertaken during the year was 1,043. A doctor was present at 348 of these confinements and in 17 emergency cases no doctor had been booked.

The total number of home visits paid by midwives concerned with the nursing care of the mother and baby after confinement was 18,917, and in addition 2,205 visits were paid to 415 patients who had been delivered in hospital, but discharged home before the tenth day. During the year the Central Midwives Board recommended that the number of days a mother should be visited after confinement should be reduced from 14 to 10 days, and this accounts for a reduction in the visits paid, both for home and hospital deliveries.

A further 10,030 home visits were paid by midwives in connection with ante-natal and post-natal examinations as distinct from nursing visits. The attendances made by expectant mothers at midwives' clinics were 5,452 and a doctor was present at 2,935 of these examinations. .

The following table indicates the number of births taking place in hospitals and at home since 1955. Allowances have been made in arriving at the figures shown, for the transfer in or out as appropriate, because of confinements which take place outside the administrative county to patients normally resident within and vice versa. It will be seen that the number of births which have taken place in hospitals has increased from 59 per cent. in 1959 to 71 per cent. in 1961, and follows closely the provision that 70 per cent. of all confinements should take place in hospital as recommended in the Report of the Maternity Services Committee (Cranbrook Report, 1958).

Year	Domiciliary Births	Institutional Births	Total	% Institutional Confinements
1955 ...	1488	2167	3655	59
1956 ...	1584	2257	3841	59
1957 ...	1473	2556	4029	63
1958 ...	1413	2473	3886	64
1959 ...	1323	2674	3997	67
1960 ...	1225	2821	4046	70
1961 ...	1128	2809	3937	71

Midwives sent for medical help, according to the Central Midwives Board rules, on 182 occasions which are listed below:—

Ante-natal Period—

Antepartum haemorrhage	2
Hypertension, albuminuria, etc.	25
Threatened or complete abortion	5
Early rupture of membranes	6
Miscellaneous	5
	43

During Labour—

Premature labour	6
Delayed labour during 1st or 2nd stage	27
Retained placenta	5
Breech presenting	2
Post partum haemorrhage and shock	13
Ruptured perineum	34
Foetal distress and prematurity	11
White asphyxia — baby	3
Blue asphyxia — baby	1
Malformation	2
Miscellaneous	14
	118

During Puerperium—

Mother—	
Pyrexia	5
Baby—	
Discharging eyes	10

Spina bifida	1
Miscellaneous	5
	21

It will be noted that on 25 occasions medical aid was requested during the ante-natal period on account of hypertension or albuminuria. The result of the confinement in these 25 cases was as follows:—

Transfer to Hospital—

(a) Normal delivery	5
(b) Twin delivery	1
(c) Caesarian section	1
(d) Surgical induction	1
(e) Forceps delivery	1
	9

Confinement at Home—

(a) Normal delivery	12
(b) Medical induction	1
(c) Still-birth	3
	16

It is important to note in the following table, which shows the age and parity of those mothers delivered at home whose parity was over 4, that there are some mothers delivered at home who come into the category of high risk cases and should have been delivered in hospital, particularly the 19 in the over 40 group and the three in the over 45 group. There are various reasons for this, one being the mothers definite preference for home confinement.

Age Group	Parity of the mother 4	5	6	7	8	9	10 +	Total
20 — ...	—	2	3	—	—	—	—	5
25 — ...	21	12	—	—	2	—	—	35
30 — ...	41	23	7	3	1	1	—	76
35 — ..	31	12	6	2	2	2	2	57
40 — ...	6	4	3	1	3	1	1	19
45 + ...	—	1	1	1	—	—	—	3
Totals :	99	54	20	7	8	4	3	195

Ante Natal Care

This year has seen the commencement of the local maternity liaison committees in East and West Cumberland, and in each case these were opened by the Chairman of the Hospital Management Committee followed by the election of honorary officers and members of the committees. The subjects so far discussed have been perinatal mortality, general practitioner obstetric beds, use of ante natal abstract cards and selection of patients for hospital confinement. There is an obvious interest in meeting together and discussing these problems.

The ante natal relaxation and mothercraft classes are continuing and expanding. During the year 221 classes were held, and 1,061 attendances made, in County Council clinics at Whitehaven, Workington, Frizington, Seascale, Millom, Cleator Moor, Egremont, Maryport and Penrith. The classes in Maryport, Keswick and Penrith have combined with the local maternity units for their patients to attend the classes. In the rural areas the midwives continue to give individual teaching to mothers in their own homes as, owing to distance and transport difficulties, they are unable to attend the clinics.

Number of cases booked for home confinement but admitted to hospital because of the following complications:—

Ante-natal Period—	
Toxaemia of pregnancy	28
Premature labour	4
A.P.H.	10
Post maturity	15
Any other reason	25
Complications of Labour—	
Delayed labour	13
Retained placenta	7
P.P.H.	4
Any other reason	14
Post-natal—	
Condition of mother	3
Condition of Baby	10

Analgesia for Home Confinements

During the year gas and air analgesia was used by domiciliary midwives in 569 cases and trilene in 272 cases. Gas and air apparatus is available to all midwives, and there are 16 trilene apparatus, four of these being purchased late in 1961. Midwives also have an oxygen infant resuscitator which is found to be most valuable in resuscitating infants born in asphyxiated conditions. These resuscitators were used 29 times during the year.

Use of Inhalational Analgesics by Domiciliary Midwives

Year	Deliveries Attended	Cases in which inhalational analgesics were administered: Doctor present at delivery — Gas & Air	Doctor present at delivery — Trilene	Doctor not present at delivery — Gas & Air	Doctor not present at delivery — Trilene	Total	%
1957 ...	1396	222	—	800	—	1022	73.2
1958 ...	1367	245	—	726	11	982	71.8
1959 ...	1265	187	7	658	118	970	76.7
1960 ...	1151	224	16	587	217	1044	90.7
1961 ...	1043	189	66	380	206	841	80.6

Post Graduate Courses

As required by the rules of the Central Midwives Board, 6 midwives attended refresher courses during the year at Hull.

The Deputy Superintendent Nursing Officer attended a post graduate course for Supervisors of Midwives in London.

SECTION 24

HEALTH VISITING

At the end of 1961 there were 23 whole-time health visitors employed out of an establishment of 24. In the rural areas of the county much of the health visiting work is undertaken by 39 district nurses, 17 of whom hold the health visitor's certificate. The remainder are employed under a temporary arrangement by dispensation from the Ministry of Health.

The staff position at the end of the year was very satisfactory as we were able to appoint 3 health visitors to fill vacancies. The health visitors have made 29,972 visits to children under one year of age and 32,113 visits to children aged 1 to 5 years. This is an increase in the younger age group and a decrease in the older age group which is the trend that might be expected as the selective health visiting has come to stay and fewer visits are paid to the older child.

During the year three nurses from the county completed their health visitor training and returned to work in the county, one to an urban area and two to rural areas. We accepted four more students who are at present in training, one at Leeds and three

at Bolton. Arrangements for the award of the scholarship have continued as previously.

Three health visitors attended the Central Health Services Council Summer School and found this a very interesting and beneficial course. Two other health visitors attended the Women Public Health Course at Leicester. Health education and the integration of mental health work into the health visitors' work were prominent subjects for discussion at this course.

During the year we have again welcomed a student from British Honduras and one from Pretoria, South Africa, both of whom spent a week in the county studying all aspects of work in a rural area. We have also welcomed students from the course in community nursing held at the Rathbone Staff College, Liverpool, and arranged by the Queen's Institute of District Nursing. Twelve health visitor students from Bolton Technical College spent a week in the county in April. These students stayed with the nurses in their own homes and this contact gives the student and health visitor an opportunity of exchanging views to the benefit of both.

Hospital Liaison

During the year two assistant nursing officers in West Cumberland have visited the geriatric units at the West Cumberland Hospital each week and have had very interesting and fruitful meetings with the physicians, almoners and nursing staff of the geriatric wards. Many problems have been solved. The hospital staff are now more familiar with the facilities available through the local authorities and the nursing officers can smooth the path for the return of the patients to their own homes, particularly where they live alone. The provision of a home help and the arrangements for a district nurse or health visitor to call are put into operation as a matter of routine and the outcome seems to be very satisfactory. A laundry service is available, by arrangement with the West Cumberland Hospital laundry, for the washing of sheets for incontinent patients nursed at home where facilities are not available.

Secondment of Health Visitors to General Practices

In my last Annual Report I offered preliminary observations on the early months of working of the arrangement whereby health visitors had for the first time been seconded to work with certain groups of general practitioners. I said then that I looked forward to this new venture being developed further, and probably extended

to other areas. This is one of the matters on which the Ministry of Health especially requested comment in the Annual Report of Medical Officers of Health this year.

This extension has gone forward and I am very much encouraged by the reports on the working of the scheme from both general practitioners and health visitors. I believe that it is being amply confirmed that herein lies the real future of fruitful and co-operative work between the health visitor and the family doctor and indeed, possibly one of the important gateways to a closer integration of the local authority and general medical services as a whole. By no means does this only apply to the work of the health visitor as far as a young child is concerned, or indeed with regard to the elderly, a growing responsibility, but I am sure that a cardinal advantage of secondment will be found in the work of the school health service. Fortunately most school nursing duties are undertaken in this authority by health visitors. Their closer attachment to general practices cannot but contribute significantly to the convergence of purpose in the services of the school medical officer and the family doctor.

The scheme commenced in the middle of October, 1960, when three health visitors were seconded, one to three single-doctor practices in Workington and the other two to group practices of four and three doctors respectively in Penrith. I was able to report favourably in May, 1961, on the first full six months of the scheme and to obtain the Committee's approval to a further extension of secondment of health visitors to the remaining practices in Workington and to all the practices in Whitehaven. This latter stage of the scheme commenced at the beginning of November, 1961, and at the time of writing this report there is an encouraging and steady build-up of work in Whitehaven and the remainder of Workington. As would be expected, I would like to comment mainly on the progress of the arrangement in the cases in which there has been already more than a full year's experience. Unfortunately one of the two health visitors seconded in Penrith became ill soon after the arrangement was established and her illness has proved very prolonged. This has inevitably thrown a strain on the work of her colleague, though a temporary appointment has been made to cover her duties and the health visitor so appointed has taken up the attachment to the group practice enthusiastically.

I feel the most eloquent assessment of the value of the secondment of health visitors to general practices must come from the individuals taking part in the scheme. It does not surprise me that the health visitors, themselves new to this pattern of working

when the scheme started, should have quickly appreciated that the horizons of their work were being brightened and enriched to a remarkable degree. What has proved even more satisfying is the testimony of most of the doctors with whom they are working, who have been firmly convinced in the first year, of the real value of health visiting service of the local authority.

One doctor writes:—

"There is, however, no comparison between those chance meetings and the present routine weekly discussions that I have with the health visitor (plus the knowledge that I know where to find her every morning if I need to) and I would be very sorry should the experiment fall through for any reason. I am sure that time will show that the immunisation rate will go up. Some mothers no longer feel that they are torn between two conflicting opinions as often happened in the past. The health visitor has shown that her services are complementary."

From another practice comes the comment:—

"From my point of view the health visitors secondment scheme has been an excellent one. I find it ideal in many ways:—

1. Ease of contact of visitor.

2. Having her present at ante-natal clinics so that she should be accepted as part of the team.

3. Filling in social background and liaison between myself and, e.g., home help service.

The scheme is particularly of use in relation to the visiting of the chronic sick and aged."

The most definite and forceful medical opinion was:—

"So far as I personally am concerned, I would rather have the health visitor abolished than return to the old system."

I do not wish to underestimate some of the difficulties which the secondment of health visitors brings, but I do feel that some of these tend often to have been over-emphasised. The seconded health visitor inevitably does more, but also more satisfying and more selective work. She will from time to time find it difficult when illness or staff shortage compels her to undertake part of the

duties of a colleague, to maintain as close a link as is, I believe, desirable with " her own " doctors. I have emphasised to all the health visitors seconded and to the doctors concerned that I feel that daily contact, brief though it may be on some occasions, is to be aimed at and this has already been achieved in most of the cases. With secondment, selective health visiting becomes an altogether more soundly based technique.

One of the first health visitors seconded in this authority reported after six months that she was having to re-design the pattern of visiting babies in their homes and with increasing contact with the general practitioners and steady extension of the work into the field of geriatrics, she states that " The day simply is not long enough." I am glad to say that this remark was made in enthusiasm, not in despair ! The same health visitor in reporting that the first six months of her work had gone very quickly, states that she has become a true family health visitor and that the doctors have sufficient confidence in her to ask her to visit homes to discuss feeding, weaning, etc., of babies in the knowledge that there will be no question of conflicting advice going to parents. I feel this is a tremendously important difficulty in health visitors' work which should be readily overcome when there is secondment to general practitioners. The same health visitor is justifiably enthusiastic about the fact that the doctors now tell mothers " Miss ——— will be calling and you will find her very helpful ".

Another health visitor comments:—

> " I am now visiting the doctors daily when convenient and seeing the visiting lists and to discuss the cause of visit and make an early call myself to the child."

And yet another:—

> " I appreciate very much being able to discuss all the various problems with the doctors as they arise."

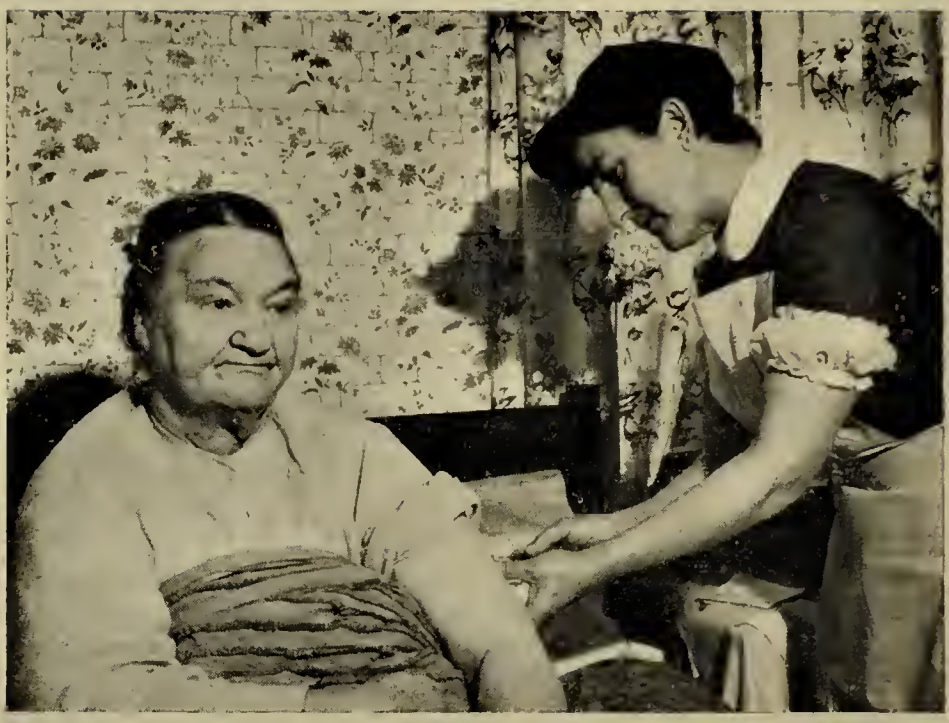
The work has shown a steady, healthy build-up since its inception, as evidenced by a further health visitor's comment:—

> " The doctors concerned have been very helpful when I have consulted them and their requests for my assistance are more frequent than in the early days of the scheme."

I feel confident, therefore, that the secondment of health visitors to general practices has proved its worth to date, and I look forward to reporting the further progress of this project in subsequent reports.

SECTION 25

HOME NURSING



At 31st December, 1961, there were employed 63 Queen's or State Registered Nurses and 13 State Enrolled Nurses who are also State Certified Midwives.

	No. of cases nursed
Medical	4564
Surgical	1488
Tuberculosis	164
Infectious Diseases	6
Maternal Complications	42
Others	111
	6375
Number of nursing visits paid	121250
Number of casual visits paid	6360
	127610

It is of interest to compare the home nursing figures for 1961 with those of the previous years:—

No. of Cases Nursed

	1955	1956	1957	1958	1959	1960	1961
Medical ...	5371	5178	5444	4946	5297	4982	4564
Surgical ...	2575	2316	1935	1897	2002	1806	1488
Infectious Diseases ...	28	13	16	12	16	8	6
Tuberculosis ...	316	189	250	250	171	114	164
Maternal Complications	71	94	112	85	69	59	42
Others ...	30	35	24	88	219	103	111
	8391	7825	7781	7278	7774	7072	6375

Analysis of Cases Nursed

		Percentage of total cases nursed
No. of cases nursed over 65 years of age ...	2495	39%
No. of cases of malignant disease	213	3%
No. of children nursed under 5 years of age ...	390	6%
Remaining cases	3277	52%
	6375	

No. of Nursing Visits to above Cases

	1955	1956	1957	1958	1959	1960	1961
Medical ...	87983	86372	99007	97337	94437	91855	92963
Surgical ...	35962	29907	29265	30073	28724	23639	20658
Infectious Diseases ...	581	84	67	81	52	81	125
Tuberculosis ...	8859	5289	6171	5886	4149	4132	3432
Maternal Complications	161	570	845	629	642	504	331
Others ...	212	715	131	237	609	815	3741
Casual visits ...	4782	5771	6493	3656	7151	6570	6360
	138540	128708	141979	137899	135764	127596	127610

Analysis of Nursing Visits

		Percentage of total nursing visits paid
Total number of nursing visits to persons over 65 years of age	71815	56%
Total number of nursing visits to children under 5 years of age	2633	2%

There has again been a decrease in the number of patients nursed and this may be due partly to the number of vacancies which have occurred throughout the year. When one nurse has to cover two areas for any length of time there is usually a decrease in attendance for home nursing care or minor ailments.

An increase is shown in the number of visits paid to "other" cases. This includes a number of visits to old people where no nursing attention is given. It is an invaluable part of the work as a talk with the district nurse often improves the mental outlook of an elderly person.

Sixty-three students from the Cumberland Infirmary, Whitehaven Hospital and Workington Infirmary, have spent a morning on the district with the district nurses. They are very appreciative of this opportunity of seeing how patients are nursed in their own homes as it is difficult for them to visualise this when they only see a patient in a bed in hospital. The district nurses are always most willing to help the students in every way they can. We have also had 15 student district nurses from Gateshead, Preston and Stockport, for three days experience in a rural area.

Eight lectures on the social aspects of disease have been given to student nurses at the Cumberland Infirmary and Whitehaven Hospital, and also to student district nurses at Gateshead Training Centre.

Miss P. G. O'Sullivan, Assistant Superintendent Nursing Officer, West Cumberland, was successful in passing the Public Health Administration examination at the Royal College of Nursing in July, obtaining a distinction in Public Health Administration. Miss O'Sullivan returned to work in the County on completion of the course.

A refresher course for district nurses at Canterbury Hall, University of London, was attended by six district nurses, and four district nurses attended refresher courses arranged by the Queen's Institute of District Nursing at Cardiff and Liverpool.

Meetings, lectures and group discussions continue to be held at regular intervals.

SECTION 26

Immunisation and Vaccination

Arrangements continued during 1961, under which protection against diphtheria, whooping cough, poliomyelitis and smallpox was available either by medical officers in county council clinics and schools, or by most of the family doctors. Furthermore as was mentioned in my last report, immunisation against tetanus has been available in clinics and schools since 1st January, 1961, and parents appear to welcome the opportunity of having their children immunised at school against tetanus.

In September, 1961, the Ministry of Health Circular 26/61 was received on "Immunisation in Childhood". This set out a full programme for the planned protection of children against diphtheria, whooping cough, tetanus, smallpox, poliomyelitis and tuberculosis. This is in fact very close in its detail to the scheme adopted in this county as from 1st January, 1961. Two possible schedules of injections were offered by the Ministry of Health, and I have agreed with the medical officers that Schedule P. as put forward by the Ministry should replace the Schedule B. to which we worked previously. There are no important differences in the two schedules. Schedule P. as now used is set out below.

Age	Visit	Vaccine	Injection	Interval
1 to 6 months ...	1	Diphtheria, Pertussis, Tetanus 1	1	4 — 6 weeks
	2	Diphtheria, Pertussis, Tetanus 2	2	4 — 6 weeks
	3	Diphtheria, Pertussis, Tetanus 3	3	
7 to 10 months ...	4	Poliomyelitis 1	4	4 weeks
	5	Poliomyelitis 2	5	
15 to 18 months ...	6	Poliomyelitis 3	6	
18 to 21 months ...	7	Diphtheria, Pertussis, Tetanus 4	7	

Smallpox during the first 2 years, but preferably at 4—5 months

School entry ...	Poliomyelitis 4 Diphtheria and Tetanus
8 to 12 years ...	Diphtheria and Tetanus Smallpox re-vaccination
Over 12 years ...	B.C.G.

Planned Protection — A well accepted programme

(a) Diphtheria Immunisation

In last year's report I mentioned that it had been possible during 1960 to improve on the diphtheria immunisation figures over the past two or three years. Unfortunately this improvement has not been maintained during the year under review as the following table shows. The figures show the total number of immunisation procedures carried out during the year.

1951	6489
1952	8915
1953	6658
1954	6880
1955	9463
1956	5221
1957	7127
1958	4024
1959	5077
1960	8245
1961	5222

The figure of 5,222 represents 4,137 primary courses and 1,085 reinforcing injections. Of the primary courses, 9 per cent. were in respect of school children, the remainder pre-school children.

The main reason for the decline in the numbers immunised was the introduction of the fourth poliomyelitis injection for school children in April. It was necessary to concentrate the medical officers' time for a period of 2—3 months on this reinforcing dose and as a consequence diphtheria immunisations were seriously curtailed.

The following table gives details of the immunity index of children in the various age groups. It has long been recognised that one of the main factors in encouraging mothers to have their children immunised is the influence of the health visitor, who can do a great deal to remind parents of this valuable service. As mentioned elsewhere in this report, the scheme for seconding health visitors to work with family doctors is now well under way in Cumberland, and I hope that this liaison will result in an increase in the percentage of children protected against diphtheria. Whether in the doctor's surgery or the county council clinic, the important factor is that the children should be protected. The place of immunisation is of secondary importance.

Protection Against Diphtheria

Year	Age of Children			
	Under 1 year	1—4 years	5—14 years	Total
	per cent.	per cent.	per cent.	per cent.
1954 ...	6	63	68	62
1955 ...	5	59	74	65
1956 ...	4	57	71	63
1957 ...	7.	56.	65	59
1958 ...	9	53	59	54
1959 ...	15	55	51	49
1960 ...	20	58	48	49
1961 ...	27	67	44	49

No case of diphtheria was reported during the year. The last case reported in the county was in 1949, but this happy fact may itself tend to lull the general public into a feeling of complacency with regard to immunisation. It cannot be too strongly emphasised that the immunity index must be improved if we are to be confident of avoiding outbreaks of diphtheria.

(b) Whooping Cough Immunisation

Notifications of whooping cough and the number of deaths from it have fallen irregularly in the past few years. Since 1956 there have only been two deaths in Cumberland, both occurring in 1957 in children under one year. The total number of notifications have fluctuated over the past ten years between a figure of 746 in 1954 to 28 in 1958. The past five year period, however, from 1957 to 1961 is the first such period in which the average number of notifications had been below 300 a year. The number for 1961 was 72. The serious possibility of pulmonary complications, especially when whooping cough occurs in early childhood, make it of continuing importance that protection should still be given to infants. At the present time combined preparations such as triple antigen (protection against diphtheria, whooping cough and tetanus) have almost entirely replaced the use of plain whooping cough vaccine.

Record cards have been received indicating that 3,169 children completed a primary course of whooping cough immunisation during 1961. This compares with a figure of 3,187 for the previous year. Of this total, only 74 children received plain whooping cough vaccine. The remainder received the triple antigen.

(c) Tetanus Immunisation

The scheme of tetanus immunisation for children in the county clinics and schools began on 1st January, 1961. It appears to be working well, particularly in the schools, and the majority of parents have taken advantage of the offer of protection against tetanus. It is the intention to give all these children reinforcement injections at five-yearly intervals until they leave school. Early in the year a meeting was held, attended by medical officers from neighbouring authorities, and the hospital casualty surgeons from East and West Cumberland, with a view to establishing a register of protected children, so that the casualty surgeons could be assured of the tetanus protection state of an injured child. As a result of this meeting it was decided to supply the casualty surgeons with a specially designed record card in all cases where a child had been immunised against tetanus.

(d) Smallpox Vaccination

During the year the number of persons receiving a successful primary vaccination was 2,408 and 510 were revaccinated. Of the primary vaccinations, 1,816 were in respect of children under one

year of age, an increase of 414 on the previous year. This is a very welcome increase, and it has been quite clearly demonstrated that patient persuasive health education is a more satisfactory and fruitful method of increasing community vaccination levels than any form of compulsion.

(e) Poliomyelitis Vaccination

In April, 1961, local authorities were informed by the Ministry of Health that a stock of oral vaccine was available for use, as an emergency measure, in the control of serious outbreaks of poliomyelitis. It was emphasised that this vaccine was not intended as a substitute for routine immunisation for which Salk vaccine should continue to be used. There was evidence that the oral vaccine could control the progress of an outbreak by interfering with the natural spread of the poliovirus strains producing disease, and it would be for the local health authority, on the advice of its Medical Officer of Health, to form a view on whether local circumstances warranted its use. The final decision as to whether the vaccine should be used would be taken by the Ministry.

With regard to immunisation with inactivated Salk type vaccine, the arrangements continued as previously. In April the Ministry of Health requested local health authorities to make the necessary arrangements to give a fourth injection to all children aged 5-12 years who had previously received three injections. This fourth injection was to be given in time to provide added protection before the summer season when the risk of contracting poliomyelitis was the greatest.

It was decided that the most effective means of carrying out this additional work would be for the medical officers to visit all primary schools in Cumberland. As such a large programme was involved, priority was given to this new scheme, and as has already been mentioned, other immunisation procedures had to be suspended temporarily. Arrangements were made for the family doctor to give this fourth injection where he had previously given the primary injections. A total of 15,399 fourth injections had been given to school children by the end of the year.

Owing to a shortage of vaccine, it was necessary in October to suspend the arrangements for giving fourth injections, and information was received at that time that Sabin vaccine (a live vaccine taken by mouth) would shortly be made available for general use by local health authorities.

Sixty-three per cent. of children aged 1-4 years had received three injections at the end of the year, and a further 13.2 per cent. had received their first two injections. The corresponding figures for school children aged 5-15 is 85.7 with 9.3 per cent. having received two injections.

The following table shows the state of vaccination against poliomyelitis by age groups and comparative figures for the previous three years.

Poliomyelitis Vaccination 1961

Total number of persons vaccinated :—

Age Group	Received four injections	Received three injections	Received two injections	Total
Children and young persons born in years 1943—61 ...	15399	33270	8776	57445
Young persons born in years 1933—42 ...	—	11418	3592	15010
Persons born before 1933 who have not passed their 40th birthday ...	—	6063	3397	9460
Others ...	—	995	844	1839
Total 31.12.61 ...	15399	51746	16609	83754
Total as at 31.12.60 ...	—	56883	14812	71695
Total as at 31.12.59 ...	—	39297	23225	62522
Total as at 31.12.58 ...	—	2294	44010	46304

SECTION 27

AMBULANCE SERVICE

During the year the ambulance service continued to be administered on a contractual basis as it has been since 1948. At the beginning of the year, the contractors consisted of nine private individuals or firms, one urban district council, one voluntary committee and the two hospital management committees, but later the voluntary committee went out of existence and a private contractor took over the service in that particular area. Sitting case cars continued to be provided by garage and taxi proprietors.

As I mentioned in my last report, although the arrangements were considered to be adequate to meet the needs when first instituted, over the years there have been growing doubts as to their efficiency by modern standards. The Health Committee decided to review the whole problem, and after giving careful consideration to all aspects of the problem, the decision was taken that the County would best be served by a directly employed and controlled service making full use of radio telephone communication. It is envisaged that there will be three main stations—one at Penrith, one at Wigton and one in West Cumberland, probably in the Whitehaven area. The Penrith station will have a sub-station in Carlisle and as it is near the main road between the West Cumberland and Carlisle hospitals and with reasonable access to Penrith, it was thought that Wigton would be the best centre for the County headquarters of the Ambulance Service.

Because of the capital cost and the difficulties involved, the whole county will not change over to a direct service at the same time. There will be three phases, the first covering the Penrith and Carlisle areas, the second covering Wigton and the third covering West Cumberland. The first phase will come into operation during 1962 and it is hoped that the others will follow at about twelve monthly intervals.

In formulating the proposals it was realised that because of their isolation certain areas would be difficult to cover economically and efficiently with a direct service and it was therefore agreed that at Alston, Keswick and Millom, contractual arrangements should continue. They will be reviewed later and it may well be that Keswick and Millom can be brought into the scheme, although it would seem that Alston may always have to be a contractual

service. Similarly, it would be very expensive to cover some other isolated areas from the four ambulance stations and while this has to be accepted for stretcher cases we will continue to have arrangements with taxi proprietors for sitting case cars to be available at an agreed cost per mile. It is not envisaged that there will be many such areas. Every effort will be made to make greater use of the British Red Cross Hospital Car Service.

The Chief Constable has been most co-operative and has agreed to the ambulance service using the police radio frequency. It is hoped to reciprocate by allowing the police the use of the radio facilities which will be installed at Wigton in the second phase of the reorganisation programme.

During the year under review the authority disposed of two old ambulances, one by sale and the other by transfer to one of the mountain rescue groups who do such excellent work in this area. Meetings were held with officials of the mountain rescue groups about the possibility of grants being made by the County Council to help in the collection and transportation of casualties from fells which are inaccessible to normal ambulance transport. The Health Committee approved the use of helicopter ambulance transport if this should ever be found necessary and arrangements have accordingly been made with the Royal Air Force.

At the end of the year the ambulance fleet consisted of 27 vehicles, of which seven were of the dual purpose type and able to carry either sitting cases or stretcher cases. This was three vehicles more than at the end of 1960 and is part of a gradual build-up to meet the needs when the direct service begins. As we will then dispense with the use of sitting case cars in almost all areas, additional ambulances, mostly of the dual purpose type, will be needed.

All vehicles continue to be inspected by the mechanics of the County Fire Service and the repairs recommended by them are carried out.

So far, the only ambulance provided with any form of equipment for oxygen administration is at Millom, where a Stephenson Minuteman apparatus was supplied in 1958. This is a machine which not only supplies oxygen, but effects a mechanical form of artificial respiration as well, a function which should be particularly valuable in cases of drowning or poisoning travelling a long distance to hospital. In fact, the apparatus has been mainly of use for the simple administration of oxygen and

in looking forward now to a directly run ambulance service staffed by personnel more thoroughly and consistently trained for the work, I propose to commence in the coming year the equipping of the ambulances with simple, easily managed apparatus for the administration of oxygen during the transport of suitable cases. Wherever possible this will be done on the recommendation of the doctor referring the cases to hospital, but cases will always occur where the ambulance staff will have to use discretion in the matter based on sound training.

The following table indicates a reduction in the total number of journeys, of patients carried and mileage compared with 1960, although it should be borne in mind that the 1960 figures showed a sharp rise over those for 1959.

It must also be borne in mind that the periods covered by 1960 and 1961 are not identical and are therefore not strictly comparable. In the past the ambulance statistics quoted in annual reports have covered a financial year, while all other statistics were for calendar years. From 1961 onwards the ambulance figures will also be for the calendar year.

	Ambulances			Sitting-case Cars			Hospital Car Service			Summary of all Services		
	Total No. of Journeys	Total No. of patients carried	Total mileage	Total No. of Journeys	Total No. of patients carried	Total mileage	Total No. of Journeys	Total No. of patients carried	Total mileage	Total No. of Journeys	Total No. of patients carried	Total mileage
'60 ...	13535	23265	257642	17273	57638	481630	680	1752	38445	31488	82655	777717
61 ...	11937	21293	251758	17716	56730	445453	587	1466	31526	30240	79489	728737
crease or decrease compared with previous year ...	—1598	—1972	—5884	+443	—908	—36177	—93	—286	—6919	—1248 (4%)	—3166 (3.8%)	—48980 (6.3%)

Civil Defence Ambulance Section

At the end of the year the total strength of the Civil Defence Ambulance Section was 429, which is a decrease of 59 from the previous year. However, it must be taken into consideration that a thorough review of registrations resulted in 92 resignations. These were for various reasons, mainly because the members had become too old, had transferred to other areas or were no longer able to take an active part in the section's work. Thirty-three new volunteers were recruited.

Officer training has been carried out as usual and local instructors attended Home Office courses for qualification, requalification or advanced training.

The section took part in an eliminating competition in connection with the regional Tourney which was held at Darlington in combined exercises with the Military and National Hospital Reserve and in a convoy exercise.

SECTION 28

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Tuberculosis

In my Annual Report last year I commented on the steady decline in the numbers of notified cases of pulmonary tuberculosis over the past ten years. In 1960, 123 cases were notified and the figure for 1961 is 90, showing the continuing downward trend in the incidence of this infection. One is always slightly anxious to establish that such a trend is a true reflection of the volume of infection in an area and not the result of any difficuly about detecting and diagnosing cases of the disease. With this in mind, a small pilot Mantoux survey of school entrant children was undertaken towards the end of the year in consultation with the chest physicians. The results of this are almost complete at the time of writing this report and I am glad to say do not indicate any hidden reservoir of infection in the areas in which this was undertaken. These are Whitehaven, Workington, Maryport and Keswick.

Only eight deaths (15 in 1960) were attributed by the Registrar-General to tuberculosis in the county in 1961. It is interesting to note that, in all, 42 deaths occurred amongst those on the tuberculosis register in 1961, showing that the majority of those still classed as tuberculosis sufferers in fact died from conditions not related or only partly related to their tuberculous infection. The following table once again shows notifications of pulmonary tuberculosis by sex and age and it will be seen that older age groups are still the most productive of cases as far as males are concerned, with the younger decades producing more cases among females.

Notifications of Pulmonary Tuberculosis by Sex and Age

	0-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65 and over
Males	—	1	—	3	5	7	10	7	14	10
Females	3	1	—	6	3	4	3	6	5	2

School children aged 13 years, numbering 2671, received a skin test in 1961 with a view to B.C.G. vaccination where necessary. Of this number 2266 (84.8%) were negative and of these 2185 were vaccinated.

Once again the department's work in the field of tuberculosis has enjoyed the fullest co-operation and help from the consultant chest physicians.

Dr. Morton and Dr. Hambridge have once again supplied full reports on the chest services in East and West Cumberland respectively and these are printed as Appendices I and II to this Report, together with Dr. Morton's report on the Mass Radiography Unit (Appendix III).

Survey on Childhood Malignancies

Between 1955 and 1957 a survey was made by Dr. Alice Stewart, Department of Social Medicine, University of Oxford, of children who had died of malignant conditions. Her results and conclusions have been the subject of international discussion and further research. She commenced in the summer of 1961, an extension of the survey to include children who have died of leukaemia or other malignant conditions since 1955.

The original survey was carried out by local authority health departments and the information sifted and analysed by Dr. Stewart. A similar pattern has been laid down for the present extension and by the summer of 1962, my deputy and senior assistants will have completed the work on the sixteen cases in Cumberland. This is quite time-consuming work involving long interviews with the parents of the deceased children and exactly the same with "control" parents for each case. This kind of important research, however, into one of the most serious remaining problems of preventive medicine can only be carried out on the necessary large scale by the co-operation of every health department in the country.

After Care of Other Illness

The following table indicates the major items of loan equipment which have been issued during the previous four years. No charge is made to the patient for this service and the continuing need for any particular item of equipment is reviewed annually.

	Items issued during			
Equipment	**1958**	**1959**	**1960**	**1961**
Commodes ...	38	15	34	49
Crutches ...	5	8	11	9
Hospital Beds ...	6	10	12	6
Invalid Chairs—				
Adult type ...	67	69	71	83
Junior type ...	6	10	11	11
Mattresses—				
Inflatable ...	—	—	3	7
Rubber ...	25	28	28	16
Tripod Walking Aids ...	15	35	53	46

In addition to the main items listed above, requests are received for an assortment of various items, and wherever the need is established every endeavour is made to provide items which enable the patient to be made as comfortable as possible in the home, and which aid domiciliary nursing. The district nurses have stocks of bed pans, bed cradles, urinals, rubber rings and plastic sheeting amongst other items, available for immediate issue, whilst the main items are distributed from Carlisle, Whitehaven and Workington

During the year arrangements have been made for the supply of incontinance pads and also a special laundry service has been established in Whitehaven in conjuction with the West Cumberland Hospital Management Committee, for the provision of clean bed linen.

Convalescence

Arrangements were once again made during the year for persons to have two weeks recuperative holiday at convalescent homes. There were 35 persons who spent a fortnight at the Silloth Convalescent Home and one who stayed at Boarbank Hall, Grange-over-Sands. They were all assessed according to their incomes and contributed towards their stay in the homes in accordance with the County Council scale of charges.

Orthopaedic Treatment

The orthopaedic physiotherapists, Miss J. Fraser and Miss J. M. Morris made the following report on orthopaedic work:—

Number on aftercare register at 1.1.61.	1683
New cases during 1961	288
New cases notified for physiotherapist only	125
Cases re-notified after previous discharge	10
Number of cases removed from register	319
Number remaining on register at 31.12.61.	1787
Number of attendances at surgeon's clinics	1177
Number of attendances at aftercare clinics	3635
X-ray examinations during 1961	119
Homes visited by orthopaedic physiotherapists	1081
Plasters applied	100
Surgical boots and appliances supplied and renewed (including insoles)	**697**

Conditions affecting children under five years of age

Flat feet	111
Bow legs and knock knees	204
Poliomyelitis	1
Scoliosis, Lordosis and Kyphosis	2
Congenital defects (including talipes and pes cavus)	44
Congenital dislocation of the hip	9
Torticollis	3
Injuries (including fractures)	2
Cerebral palsy	24
Postural defects	4
Hallux Valgus and deformed toes	8
Birth palsy	2
Osteomyelitis	1
Other conditions	42
	457

Conditions affecting school children

Flat feet	315
Bow legs and knock knees	264
Poliomyelitis	49
Scoliosis, Lordosis and Kyphosis	16
Congenital defects (including talipes and pes cavus)	101
Congenital dislocation of the hip	28
Torticollis	6
Injuries (including fractures)	8
Cerebral palsy	68
Postural defects	54
Hallux valgus and deformed toes	27
Birth injuries	7
Osteomyelitis	1
Perthes disease and coxa vara	14
Arthritis	1
Spina bifida	7
Synovitis and Rheumatism	4
Schlatter's disease	1
Muscular dystrophy	4
T.B. joints	6
Paraplegia	2
Other conditions	66
	1049

Conditions affecting adults

Flat feet	14
Bow legs and knock knees	2
Poliomyelitis	19
Scoliosis, Lordosis and Kyphosis	15
Congenital defects of feet and otherwise	18
Congenital dislocation of the hip	13
Injuries and fractures	28
Cerebral palsy	20
Postural defects	1
Vertebral disc protrusion	33
Hallux valgus and deformed toes	9
Birth palsy	3
Osteomyclitis	2
Perthes and coxa vara	3
Arthritis	21
Spina bifida	5
Synovitis and Rheumatism	1
Slipped Epiphysis	4
Dystrophies	2
Achondroplasia	1
Bone and joint T.B.	60
Paraplegia	2
Other conditions	5
	281

During the past 15 years the over-all picture of the orthopaedic physiotherapy scheme has altered greatly. In former years a great deal of time was spent on the treatment of tuberculosis of bones and joints, and of anterior poliomyelitis cases, but now, owing to the decline in the number of cases affected by these diseases, more time is spent on the treatment of the so-called "flat foot," and the early correction of bow legs and knock knees.

Opinions differ as to whether treatment of the latter two defects is necessary. Some believe that the defect should be left untreated as the limbs will straighten as the child grows, but in our experience if a case of severe bow legs does not receive early

treatment there is a resultant kink in the lower third of the tibia with an associated valgoid ankle, faulty gait, and faulty wear of shoes. This is difficult to correct in the older child, so it is imperative that the child should be referred for treatment as soon as possible, preferably when under two years of age. We would also urge that cases of knock knees are referred at an early age; the child, if untreated, develops an associated flat foot, ugly gait, and faulty wear of shoes.

Knock knees are frequently found in the overweight child. In such a case the child will not benefit from treatment unless it is accompanied by a reduction in weight. This can only be achieved with the co-operation of the parent, and it is sometimes difficult to make some parents realise that being overweight for his height and age could be detrimental to the child's health and future well-being.

There has been in recent years an increase in the number of cases of hallux valgus and other toe deformities, which may possibly be attributed to unsuitable footwear. Quite a number of children who are referred for treatment have only a mild foot defect, but have developed a bad gait, and therefore wear their shoes down badly. This is not helped by the soft, slip-on type of shoe which is all too frequently worn by school children these days. Re-education in correct walking, combined with the wearing of firm, lacing shoes is often found to be the only treatment necessary.

In cases of more serious foot defects, bow legs and knock knees, minor alterations to well fitting lace-up shoes are almost always advised, usually consisting of a small wedge on the inner side of the heel and occasionally on the sole as well. When the child combines a bow leg or knock knee with an intoeing gait, the wedge on the sole is on the outer side.

It is at times difficult to ensure that these shoe alterations are correctly carried out, and we have found it advisable to have the child's first pair of shoes altered to our directions by a qualified shoemaker, in Carlisle, who works under the National Health Service. Subsequent alterations may then be carried out by shoe repairers in the child's own locality.

We find that treatment of the physically and/or mentally handicapped child is often best carried out in the home, rather than the clinic. It is easier to put the child at ease and gain his

co-operation in surroundings which are familar to him. There is a decided advantage in seeing the child in his own environment, and in understanding the family circumstances. One is accepted as a family friend, and thus can more readily advise the mother on the correct handling and management of the child.

The father may also be of assistance in altering a push chair, or walking aid, or adapting the family bicycle for the use of the handicapped child by the addition of blocks and straps.

Good results have been obtained amongst children with a spastic hemiplegia or paraplegia, who tended to go up on their toes, by the application of corrective plasters followed by the wearing of an iron and stirrup strap. These conservative measures have made operative treatment unnecessary.

An interesting aspect of the orthopaedic scheme which has been developed is the domiciliary physiotherapy treatment of the adult hemiplegic patient who is being nursed at home. Here again we urge that patients be referred as early as possible, otherwise contractures and stiff joints result. These patients are often elderly, but nevertheless eager to retain their independence. By treating them in their own homes we are in a position to make suggestions regarding gadgets for the kitchen, bathroom, etc., which will enable them to carry out their domestic duties, though handicapped by the loss of muscle power in one arm.

Constant supervision of old cases of poliomyelitis, particularly through their growing years, is still a vital part of our work. Splintage supervision, stretching and exercises and the use of plaster night shells are all necessary to prevent deformity where a strong group of muscles pulls against a weak muscle group.

A difficulty which we constantly meet is to find a shoe with a solid leather heel which will take the socket for an iron or caliper. The heels of modern footwear are invariably made of rubber or some composite material which is useless for this purpose. Specially ordered shoes with leather heels frequently take weeks to arrive.

In many cases of poliomyelitis and in some congenital foot deformities in children where one foot is smaller than the other, providing satisfactory footwear is very difficult. If there is serious foot deformity as well as a difference in size then hand-made surgical boots are indicated. In a growing child this becomes an

expensive item and can only be recommended when absolutely necessary. The alternative, i.e., to obtain through local stores two shoes of different sizes, is becoming increasingly difficult. Very few of the well known makers of children's shoes will agree to supply these. One or two of the large multiple firms do undertake these orders and carry them out in a comparatively short time, at a small additional charge. Even these firms, though continuing to supply the needs of patients already on their books, are unwilling to accept new customers. It is an urgent matter to find a solution to this problem.

Prevention of Blindness, and Care and After-Care of Blind or Partially Sighted Persons

A. Follow-up of Registered Blind and Partially Sighted Persons.

	Cause of Disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Others
(i) Number of cases registered during the year in respect of which Section F of Form B.D.8 recommended :—				
(a) No treatment ...	10	1	—	28
(b) Treatment (Medical, surgical or optical) ...	*14	7	—	23
(ii) Number of cases at (i) (b) above which on follow-up action have received treatment ...	5	7	—	13

* Received treatment: 5 Delayed treatment — under Hospital supervision: 4 Treatment not yet carried out.

(These cases are being followed up by visits from Health Visitors)

B. Ophthalmia Neonatorum.

There were no cases notified during the year.

Health Education

A very full report on the development of health education in the clinics and schools was given in the Annual Report for 1960, and throughout the present year the work has continued on the same lines and is progressing satisfactorily.

In September the Assistant Superintendent Nursing Officer for Health Education left the county and the post has not so far been filled.

Health Education in the urban areas, where it is more convenient for mothers to attend clinics and where there are full-time health visitors, is more easily organised. In some of the rural areas there has been an acute shortage of staff which has of necessity temporarily reduced the activities in this branch of the work.

Relaxation and mothercraft classes have been extended and courses were started at Keswick, Maryport and Penrith, each centre being supplied with a projector, filmstrips and demonstration material, and appropriate leaflets are given to the mothers at the conclusion of the class. In each case a preliminary meeting was held with the Matron of the maternity unit, and it was decided that patients booked for hospital should be notified to attend the classes. This was enthusiastically taken up and the results have been very satisfactory. The general practitioners were consulted and were readily in agreement to their patients attending the classes. The number of patients attending continues to increase.

Since the one-day course held at Cockermouth in November for organisers of the old people's welfare committees and clubs there has been an increasing demand for talks to groups of over 60's at the various centres and clubs. These have already been given at Dalston, Wigton and Great Corby W.I. Requests have also been received from Alston and Threlkeld. Provided there is some visual aid and the talk is not too long, the audiences are usually very interested. With age the importance of a balanced diet for continued good health, and the necessity of adequate lighting in the home for the prevention of accidents, has often been forgotten, and a talk with an attractive filmstrip or flannelgraph is a useful reminder and may have quite unexpected results.

The administrative staff, health visitors and district nurses have given courses of lectures to the British Red Cross Society, St. John Ambulance Brigade and Civil Defence at seven centres in the county, and lectures have continued to be given to the nurses in

training at the various hospitals in the county. Four lectures on emergency midwifery were given to the members of refresher courses held at the County Constabulary, Carleton Hall, Penrith.

Equipment for health education has been extended and two projectors, a blackboard, display unit and many topical filmstrips have been purchased and are in constant use. The idea in the future is to set up more centres in the county to serve the surrounding rural areas, and stock these centres with the appropriate equipment, so avoiding overlapping or delay. It is hoped that next year the county will purchase a record player and a tape recorder. These would be useful in the health education field, especially with the introduction of mothers' clubs.

Health Education was a special feature of the postgraduate courses which were attended by health visitors. This has a wider impact than is realised at the time as the information gained is disseminated amongst the health visitors at staff meetings. Following a lecture on " Mental Health " one of the health visitors sent in a report on the group discussion from which the following is an extract :

" After the lectures we had group discussions and from the group discussions, in which I took part, we prepared the following report:—

Can positive health be measured or defined? Does it apply to one community or to the whole world? Does mental and positive health relate to the individual or the community? Should mental health be the first consideration in measurement of positive health?

We discussed the fact that rural communities appear to be able to absorb a great deal of punishment in the way of hazards due to weather and cattle disease, and if this was environmental rather than hereditary could not urban societies be conditioned. Family life was much closer in rural areas than urban areas.

In considering the basic needs and the longer expectation of life we decided that the desirability of this depended on the quality of life and its contribution to society.

Joining a group could be either instructive or destructive. It was felt that a group should be creative and an element of social service was necessary. Was our approach to social services too

formal? Could one not benefit society by just being oneself. Have the welfare services undermined the mother's confidence, e.g., until recently we insisted on feeding a baby by the clock, now we had completely changed our policy and feed on demand."

Another group discussed " Positive Health ", the World Health Organisation definition being " Health is a state of complete physical, mental and social well-being and not merely the absence of infirmity ". The health visitor made the following comments on the group discussion:—

" The group commenced by attempting to define " Positive Health " and the means of measuring it. The majority felt that the World Health definition was the best, and thought we needed more time to stand and stare. Some of the group would like to reduce the pace of modern living. We all felt the need for the return to religion. In the West the main clash was between science and religion, but for the remaining five-sixths of the world the problem was population difficulties. We discussed birth control, selection in breeding and compulsory sterilization, and reached the conclusion that this was not possible on ethical grounds. Education and birth control was of paramount importance.

The group considered the question : Is progress a result of circumstances, and does the modern world need protection from the under-developed countries. We must realise that disease may be spread. We decided that the West must give material aid, and that education in all forms was the major priority, that birth control was important with the facilities available, and education for the need of it ".

New trends and developments are fully discussed and put into operation where practicable.

Health Education has continued to expand in the secondary modern schools and there is a special syllabus for housecraft in which the health visitors and nurses take a part. The field of these lectures has been rather wider, including buying a house, furnishing a house, budget planning and choosing a career.

Health visitors, district nurses and midwives throughout the county have attended group meetings held in ten centres. New films have been shown and the staff have had opportunity for discussion both between themselves and with the administrative staff.

Posters and leaflets have been distributed for use in clinics and schools, and to help with the general health educational work.

Perhaps the highlight of staff in-service training last year was in November when sixty health visitors and nurses attended a course given by Professor Sir Alexander and Lady Ewing, and Dr. Taylor, on Screening Tests for hearing in children under five years of age. Techniques were demonstrated to enable all health visitors to undertake initial hearing tests in the age groups 7—16 months, 16—30 months and 30 months—5 years. Any children found with a defect are referred for further testing.

Teacher of the Deaf using speech training unit

Chiropody Service

In my last report I mentioned that the Authority's free chiropody service for the elderly, expectant mothers, and the physically handicapped had been in operation only two months, but that first signs were of a fairly rapid "build-up". This trend has continued throughout 1961, although towards the end of the year the number of new cases referred for treatment each week seemed to have settled to a steady 25.

At the beginning of the year 624 people had been recommended for treatment, 96 per cent. of whom were elderly (men of 65 years of age and women of 60). They were being treated by 13 chiropodists, all of whom were employed on a sessional basis, and in total they worked 15½ sessions a week. A full-time chiropodist, Mr. C. H. Thomas, M.Ch.S., had already been appointed and he took up duty on 16th January, 1961, being based in West Cumberland and giving treatment in the Egremont, Whitehaven and Workington clinics, as well as giving domiciliary treatment to those who, on medical grounds, were unable to travel to those clinics and who lived in an area stretching from Distington in the North to Eskdale in the South. In addition, he was

seconded to the West Cumberland Hospital Management Committee and gave treatment to hospital patients for two sessions each week.

At the end of 1961 the total number of people referred for treatment was 2,153, an increase of 1,529 during the course of the year. To meet this demand it was necessary to increase to 39 the number of sessions taken up with chiropodists working in private practice and the full-time chiropodist had so many patients on his books that the authority decided to advertise for another full-time person but, as was rather expected, there were no applications and efforts were therefore turned to recruiting further part-time staff.

The patients needed a total of 8,585 treatments during the year, 7,850 or 91½ per cent. being for the elderly, 693 or 8 per cent. for the physically handicapped and only 42 or ½ per cent. for expectant mothers. The referrals have borne out the general expectation that the service would largely be for women, as 78 per cent. of all the treatments were for them, but the amount of time spent on domiciliary work exceeded expectations. It was 20 per cent. of the total, mostly because of the high proportion of physically handicapped persons who had to be seen at home.

The full-time chiropodist, who of course gave more treatment under the Authority's service than any other chiropodist, reports that the conditions presented ranged from relatively minor cases to extremely severe cases of neglected feet associated with major foot deformity and that quite frequently it is the provision of chiropody treatment alone which keeps an elderly person ambulant and prevents total incapacity. Many patients are chronic cases, but even so much can be done to maintain them at an optimum level of comfort by regular treatment. The relatively small number of expectant mothers he saw presented minor foot disorders which he considers could, in all cases, be attributed mainly to unsuitable footwear. All admitted to foot trouble prior to pregnancy and stated that this had not been increased unduly during their term. The physically handicapped persons who received treatment included blind patients, those with limbs amputated, paraplegic, hemi-plegic and the mentally handicapped. In addition, many who could have had treatment as handicapped persons qualified on age and were therefore referred to me in the elderly group.

Apart from the time taken for domiciliary visits, difficulties arose from time to time because of inadequate lighting and the

absence of power points, but with the co-operation of the chiropodists and the patients they were overcome. In some cases this was accomplished by providing transport to take the patient to a clinic for treatment.

Another interesting point which emerges from the records of the full-time chiropodist is that 8 per cent. of the appointments made were not kept and he was not warned that this was likely to be the case. In a service dealing mainly with the elderly this is probably not an unduly high absentee rate, but when chiropodists' time is at a premium it is a pity that such a large percentage of it must be wasted.

Based on the national percentage for the need for chiropody amongst the elderly, we still have some way to go in Cumberland before the peak is reached as only 7 per cent. of the elderly in the County were being treated by the end of 1961, despite the rapid expansion of the service. However, doubts have been cast on the accuracy of the 17½ per cent. which is often quoted as a national figure and in an attempt to get a clearer picture of the situation locally, I got the agreement of a number of general practitioners who had been chosen at random, to carry out a survey among their elderly patients. The patients were also chosen at random and the following facts emerged:—

11 per cent. are in need of immediate treatment.

25 per cent. would benefit from chiropody treatment whenever possible (that is, they are caused inconvenience without serious restriction to social activity).

8 per cent. need some attention, but this can be given by relatives, friends, etc.

56 per cent. do not require treatment.

If these figures are broken down according to sex, we get the following results:—

Of those in immediate need	... 27 per cent. are men and 73 per cent. are women.
Of those who would benefit from treatment whenever possible.	... 35 per cent. are men and 65 per cent. are women.
Of those who need some attention, but can receive it from others than chiropodists.	... 48 per cent. are men and 52 per cent. are women.
Of those who do not require attention.	... 57 per cent. are men and 43 per cent. are women.

I would like to thank the doctors for their co-operation. Without it the survey would not have been possible.

When the chiropody service was introduced it was thought that for various reasons it would probably be fraught with difficulty. However, after the first full year I am pleased to be able to say that by and large there have been few difficulties and with goodwill and co-operation all round they were quickly resolved. For this, I would like to thank especially the chiropodists and the Old People's Welfare Committees who act as the Authority's agents in certain areas and without whom, in present circumstances, these areas would have no service or one much restricted. One point which is now beginning to give cause for concern is the shortage of suitably qualified chiropodists. I fear that unless the situation improves the future expansion of the service will be severely restricted by the inability to get staff, especially as many of those already employed by the authority have almost reached the limit of the number of patients they can accept.

Venereal Diseases

I am indebted to Dr. H. J. Bell, Consultant Venereologist, for his permission to publish the following extracts from his annual report to the Special Area Committee of the Newcastle Regional Hospital Board:—

For some years the following table has had a place in my Report:—

Table I

Year	Early V.D. Infections		Total Attendances	
	Carlisle	Whitehaven	Carlisle	Whitehaven
1952	51	13	2081	870
1953	43	17	1924	976
1954	48	18	1461	619
1955	48	26	1202	641
1956	60	23	909	450
1957	45	17	741	362
1958	45	22	806	301
1959	69	20	893	398
1960	74	20	920	472
1961	67	39	755	454

The expression "Early V.D. Infections", includes patients attending for the first time with the main venereal diseases. The numbers of these cases attending Cumberland Infirmary last year were slightly less than in 1960, but those attending Whitehaven were markedly increased. As pointed out in previous Reports, these figures for early infection do not represent the real incidence of V.D. in the area. Many men and women are treated by their family doctors. The minor variations occurring as between one year and the next are probably not significant—the numbers being so small. Over a number of years, however, it would be permissible to deduce the trend in infection. In 1961 there were no cases of congenital syphilis treated at the Clinics.

The totals of all new cases are included together in the following table:—

Table II

Year	New Cases seen for the FIRST TIME CARLISLE	WHITEHAVEN
1952	274	95
1953	250	92
1954	219	87
1955	168	74
1956	136	78
1957	173	61
1958	191	45
1959	213	63
1960	248	72
1961	240	101

It is shown that the volume of work at Carlisle was much as last year, but that the Whitehaven Clinic was much busier than usual—the figure is the highest for ten years. I know of no particular reason why this should be so, but the early months of 1962 have demonstrated, already, that this tendency continues, and it is likely that 1962 will show a further increase.

Gonorrhoea is the most important venereal disease in this country, at the moment, and the table following gives together the patterns of infection in England and Wales, Scotland and Carlisle:

Table III

Year	Fresh Cases of Gonorrhoea										Percentage increase over 1955
	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	
ENGLAND AND WALES ...	19095	19263	17536	17845	20388	24381	27915	31328	33640	37026	107%
SCOTLAND ...	2863	3251	2798	2545	2708	2831	3324	3382	2937	2959	16%
CARLISLE ...	26	16	22	21	38	25	28	34	42	36	71%

It will be obvious that the figures for England and Wales still follow the steep upward trend which began in 1955. In a graph, the increase still shows as a straight line. The contrast with the Scottish statistics is remarkable. To emphasise the difference, it would be sufficient merely to compare the numbers in 1961 with those in 1955. In the one case the percentage increase is 107, in the other it is only 16. The percentage increase of 71 listed for Carlisle must be interpreted with caution since this clinic draws patients from all over Cumberland, from Dumfriesshire, and far beyond, and because the actual figures are small.

Although the fundamental cause of the vast increment in the English figures is still unknown, the broad pattern of the new situation is becoming easier to analyse. For instance, it is now realised that the volume of infections among West Indians is centred entirely on the largest cities, and that London deals with nearly as many cases of gonorrhoea in the general population as the rest of the country put together. This research has been carried out by the British Cooperative Clinical Group to whose statistics all Venerologists in this country contribute. Apart from the above, they showed that in 1960, only about half of the cases of male gonorrhoea treated in this country were native born. Of the rest, more than a quarter were West Indians. In urban centres with a population of 50,000 inhabitants or less, the proportion of West Indian patients was under 4 per cent. of total cases, and in Scotland it was less than 1 per cent.—and no West Indians have been treated in Cumberland. Furthermore, the Clinical Group proved that there is no relationship between the rise of teenage infections in this country and infections among West Indians. They scanned twenty clinics in which West Indian infections were especially prevalent, and found that no increase in teenage infections had shown up in these same areas.

A further interesting derivative of their report dealt with this problem of teenage gonorrhoea. " The age group studies tended to show a greater proportion of gonococcal infections in young persons of both sexes in the smaller towns than in the larger cities. A comparison with earlier studies showed that a significant increase in gonorrhoea in young persons had occurred since 1957." The largest increases then have been in boys and girls of the 15 to 19 years group.

My personal feeling is that our troubles in controlling gonorrhoeal infection centre on the problem of the female case. For years we have realised that there must be in existence a reservoir

of infection in women, because the disease is often free of symptoms in her case and because, for one reason or another, the majority of women never come to treatment at all. What is new is the growing realisation among Venereologists that so many women seem to become carriers of a relatively avirulent organism and appear to remain as carriers for such a long time. The difficulty is only increased by the further realisation that diagnosis in the female seems to become a matter of increasing difficulty as the years go by. That some of these cases harbour a gonococcus partially resistant to penicillin only adds to one's perplexity. The most superficial study of a selection of case histories where more than two people are involved removes the problem quite beyond a matter of mere speculation.

Here is one such story: From a seaman a female received a gonococcal infection and passed it on to a lorry driver who showed no symptoms because the infecting organism was weak or " avirulent ". The latter's wife subsequently acquired the disease from him—now virulent in " new soil " and despite treatment suffered an acute internal complication requiring operation. Later, the husband took his original consort for examination and only after prolonged and sometimes conflicting investigations, was it proved that she was infected.

This case history illustrates so completely the points I have been making. Gonorrhoea in women must often be impossible of diagnosis with the facilities available to the clinician at the present time. This means that some women presenting themselves at the Clinics will be passed as clear of infection when, in fact, this is not the case. Likewise, when the doctor has treated a gonococcal infection in a woman, how is he to be sure that he has been successful?

I see little hope of relief from the present predicament unless methods of diagnosis can be improved. Primarily, there is urgent need of a reliable serological test. Knowledge of the antigen

fractions of the gonococcus may lead to such a development. Certainly the current "Gonococcal Fixation Test" has such limitations that I have abandoned it in my Clinics. Cultural techniques vary from laboratory to laboratory, and results from the point of view of the clinician, are still too unreliable. In the face of a situation where gonorrhoea is becoming almost a national scandal, we appeal to the pathologists to give all the help they possibly can.

I have made very little comment in recent years about syphilis. Although the Americans and Italians have been reporting a significant increase in statistics of early (infectious) syphilis for five years or so, no real changes have revealed themselves in the Minister's figures until 1961. It can now been seen in retrospect that since 1958, there has been a small but steady increase of these early cases (6 per cent.). The only patient reporting in Cumberland during this last year, had acquired his infection elsewhere. I had always hoped for the complete eradication of syphilitic infection, but it seems we must still be on our guard against an occasional sporadic outbreak. The figures for late syphilis in Cumberland have remained, more or less, the same for the last eight years. The majority are examples of neurosyphilis, and many of these are cases of G.P.I. (General Paralysis of the Insane). Tabes dorsalis has become a rarity. Elsewhere in England, the trend has been downward during the same period, but there was a curious upswing in 1961. Opinion is divided as to whether or not G.P.I. is becoming increasingly common throughout the country.

It is a great pleasure to welcome a new and highly specific blood test for syphilis. The Wassermann test has been invaluable to syphilologists for more than half a century, but it is not truly a specific test. The deficiency has been filled by the introduction of the R.P.C.F.T. (Reiter Protein Complement Fixation Test) which Dr. Faulds now carries out in the Cumberland Infirmary.

Finally, I append a table showing the place of origin of the new cases which attended the two clinics in Cumberland during 1961.

Table IV

Town or Area	To Carlisle Clinic	To Whitehaven Clinic	Total
FROM—			
Carlisle and suburbs ...	88	—	88
Aspatria ...	6	—	6
Brampton ...	1	—	1
Cleator Moor ...	—	3	3
Cockermouth ...	4	3	7
Distington ...	1	—	1
Dumfriessshire ...	16	—	16
Egremont ...	1	4	5
Frizington ...	—	5	5
Gosforth ...	—	1	1
Holmrook ...	—	3	3
Keswick ...	6	—	6
Longtown ...	3	—	3
Maryport and area ...	8	1	9
Millom ...	1	1	2
Penrith and area ...	20	—	20
Ravenglass ...	—	1	1
Seascale ...	—	1	1
Silloth ...	5	—	5
Spadeadam ...	1	—	1
Whitehaven and area ...	9	34	43
Wigton ...	4	—	4
Workington ...	11	37	48
Others ...	55	7	62
	240	101	341

MENTAL HEALTH SERVICE

The period under review represents the first full year during which the Mental Health Act, 1959, has provided the charter for the local authority's mental health services. The local authority's chief contribution is the provision of a maximum of care and support within the community for every mentally disordered person who can benefit from this. With the replacement of former legislation, local health authorities have now a statutory duty to provide a community care service which includes the mentally ill. To this authority this was a new field, ill defined in size and with boundaries which depend on changing conditions in the therapeutic services for the mentally disordered. Our first full year's work has demonstrated that we can make a very significant contribution to the prevention of mental illness and the promotion of mental health through the domiciliary care service. I will deal in a little more detail with this aspect of the work before giving an account of the authority's other responsibilities in the mental health service.

Domiciliary Care Services

At the beginning of the year three types of officer were involved—psychiatric social workers, full time mental welfare officers and a number of officers (the duly authorised officers) whose part-time duties in mental welfare were limited to statutory duties in the admission of patients requiring detention in mental hospitals. The policy of manning the local health authority's mental health service by fully trained, whole-time officers undertaking all aspects of domiciliary social work has been actively pursued and the benefits are now being realised from the Council's inservice training schemes which were started in 1958.

Some readjustment of the establishment of field officers in the mental health section became necessary during the year as a result of the recommendations of the Working Party on Social Workers (Younghusband Report) and the modified salary structure there proposed. Two posts designated "psychiatric social worker" were deleted from the establishment (one being vacant) and replaced by one post of Senior Mental Welfare Officer and one of Mental Welfare Officer. At the end of the year, in addition to the Mental Health Officer, the establishment of one senior mental welfare officer and six mental welfare officers was filled. The senior mental welfare officer qualified as a psychiatric social worker under the Council's scholarship scheme, after a year's training at Manchester University.

From the 1st November, 1961 (the first anniversary of the Mental Health Act) it became possible to dispense with the services of part-time officers in the East Cumberland area—the needs of that area being met entirely by full-time mental welfare officers. I expect to be able to do the same in West Cumberland in the early summer of 1962. To overcome the peculiar geographical difficulties associated with Millom, I am most grateful to Dr. T. F. M. Jackson (Assistant County Medical Officer and Medical Officer of Health for Millom Rural District) for accepting appointment as a mental welfare officer for that area.

A group no longer formally screened for possible need of supervision in the community are the E.S.N. school leavers. After discussing this question with the Director of Education and all the workers involved, I have come to the conclusion that support should be offered by the local health authority to any educationally subnormal child whose future on leaving school seems to present serious hazards. All educationally subnormal scholars are now being reviewed in their final year at school by the school medical officer who will have before him an up-to-date report by the educational psychologist. If the child is thought to face hazards such as unpromising employment potential, the possibility of moral danger, unsatisfactory environmental conditions with a possible drift into delinquency, the school medical officer recommends that the child should be followed up on leaving school. The aim is to maintain a continuing, if infrequent, contact with the boy or girl and his or her family for as long as may be required. This form of informal and discreet supervision will usually be undertaken by a health visitor who collaborates with the mental welfare officer in those cases where the latter's more specialised skill may prove useful. I regard this as an important preventive measure for a group of young people who, though not subnormal, are vulnerable because of their handicap, plus in most cases, some other factor or factors weighing against them. Here I feel the broadly based experience and skill of the health visitor is appropriately deployed.

The figures which follow show clearly that a real need existed for community care services for the mentally ill when the Mental Heath Act came into force. There seems no doubt that the more efficient and highly developed an authority's pre-care and after-care services, the greater will be the demands upon them and the less will be the need for hospitalisation. I am sure that, in keeping with up-to-date trends, we must spare no effort to keep the mentally sick and subnormal within the community wherever possible.

but the critical factor in the rate of development may very well be the provision of trained staff rather than of buildings.

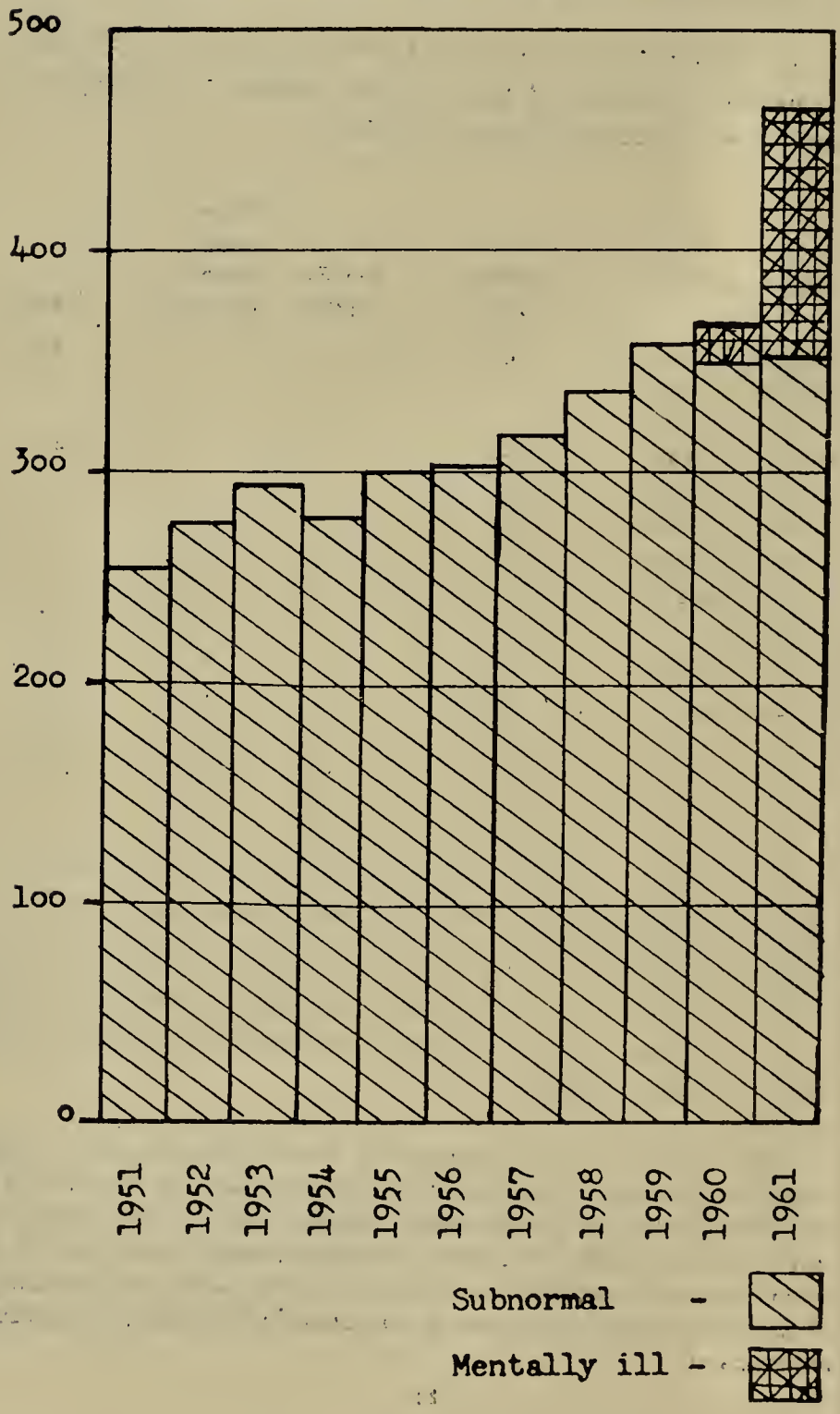
The following table shows the number of patients referred to the authority during the year with an analysis as to category of mental disorder and the source of referral:—

Source of Referral	Mentally ill	Psycho-path	Subnormal and severely subnormal	Total
General Practitioners ...	46	—	5	51
Hospitals—on discharge from in-patient treatment ...	82	1	3	86
Hospitals—after or during out-patient or day treatment ...	28	—	5	33
Local education authorities ...	—	—	10	10
Police and Courts ...	11	—	3	14
Other sources ...	26	—	9	35
	193	1	35	229

These figures illustrate the demands on the local authority's domiciliary mental health services of the first complete year of the Mental Health Act. The extent of the co-ordination of the psychiatric hospitals' and the authority's services may be assessed by the proportion of cases (119 out of a total of 229) which were referred by the hospitals.

The ultimate extent of need for local authority services and therefore also staff requirements are still difficult to forecast. The table above and the graph which follows (showing the number of cases receiving visits from mental welfare officers at the end of the year) indicate the substantial increase of total cases and the change of emphasis towards the care of the mentally ill in their own home environment.

Mental Welfare Officers
Domiciliary Case Load at 31.12.1961



It is interesting to note to what extent it has been found necessary to use Part IV of the Mental Health Act, 1959, relating to compulsory admission to hospital during the first full calendar year during which the Act has been in force. Application for compulsory admission for observation under Sections 25 and 29 of the Act, giving power of detention to a maximum of 28 days, were completed in 84 cases, but in only 13 of these was it necessary to detain the patients compulsorily for longer periods by taking action under Section 26 of the Act. Of the total number originally admitted for observation, 82 per cent. (69 patients) were either discharged or transferred to informal status during the validity of the authority for detention.

Applications for treatment under Section 26, giving authority for detention for not more than a year, were completed in 25 cases in all, including the 13 mentioned above.

Mr. Mayoh, Senior Mental Welfare Officer, makes the following observations:—

" The mental welfare officers regularly visit the subnormal and the severely subnormal in the community, the frequency of the visits depending upon the need in each case. By these means mentally subnormal members are helped to remain in the community, and the knowledge that a representative of the local authority is concerned about their welfare is a source of considerable comfort and support to the families concerned. When necessary a short stay in hospital or local authority hostel is arranged.

An increasing number of visits are paid to the mentally disturbed. Patients who will benefit from after-care visits after discharge from hospital are seen in the hospital and at home, and both the patient and his family are given support in this difficult transition period. Hospital admission is sometimes avoided by means of visits by a mental welfare officer after early referral from various sources.

A very close working relationship with the medical staff of the hospitals and general practitioners is maintained."

I would like to quote three cases illustrative of the work of the mental welfare officers:—

Case A is a married man of 38 years, whose paranoid behaviour had considerable nuisance value for many years. He was

not considered certifiable under the earlier legislation, was unwilling to accept treatment either from his general practitioner or a psychiatrist and, having little insight into his condition, resisted hospitalisation. He had little support from his wife (of subnormal intelligence) and was struggling to earn a living from a poor farmstead. His delusions persistently took the form of groundless allegations of theft of various types by neighbours. There were occasional attempts at physical violence. During a depressive period, he sought advice from the casualty department of a general hospital, and was persuaded to enter a psychiatric hospital. His condition was diagnosed as one of paranoid schizophrenia with systematised delusions, and having improved dramatically after nearly three months' treatment, he was discharged from hospital. A case conference was attended by the consultant psychiatrist responsible for treatment and the patient's general practitioner, in addition to the authority's officers. It was agreed that aftercare supervision by a mental welfare officer was essential and that the most appropriate officer would be one with a background of psychiatric nursing which provided experience in observing changes in conditon and in the general management of this type of illness.

The general practitioner assumed medical responsibility for the patient whilst at home, and the mental welfare officer undertook to provide social support, to observe on behalf of the doctors any manifestation of deterioration or aberration, and to encourage psychiatric follow-up through the out-patient clinic.

Intensive social support has been given by the mental welfare officer over the seven months since discharge, and a positive and fruitful relationship has been established with the patient. There have been no relapses, and the last report from the psychiatrist reads " Remission appears to be fully maintained. Denies any persecutory ideas and there is no evidence of any other psychotic symptoms ". Relationships with neighbours (previously the subject of the patient's violent animosity) are now constructive. The intervals between clinic follow-up has been lengthened to five weeks and the mental welfare officer's visits are reduced to one every two or three weeks.

Case B. This patient is a spinster, aged 62, who lived alone in an extremely isolated detached farmhouse on a fellside near the Scottish border. The circumstances under which her difficulties came to our notice are unusual. She was leading a hermit-like existence and only emerged from the house once a week to collect supplies from a travelling grocery van. Neither the family doctor

nor the district nurse could gain admission to the house and were only able to catch fleeting glimpses of the patient through a rear window. The mental welfare officer who tried to assess the situation by timing visits to coincide with the weekly visit of the grocer was equally unsuccessful in making any contact.

Although severe wintry conditions prevailed, the patient did not appear to have any form of heating—she had bought no form of fuel and the house had neither gas nor electricity laid on for many months. The only food she bought was bread, potatoes, tomatoes and tinned cat food. No light was ever seen and no smoke came from the chimney. She was described by the van driver as "vigorous" for her age and reasonably clean, but had no known source of income and was allowed to accumulate a considerable debt for groceries as she had no money. As the kindly grocer explained—" I can't just let her starve ".

In consultation with her doctor it was decided that there was adequate grounds and urgency in the woman's interests for forcible entry under Section 135 of the Mental Health Act. A warrant was obtained, and accompanied by the doctor and mental welfare officer, a police sergeant was prepared to break into the house. This proved to be unnecessary because the patient unbolted the door and made a feeble attempt to attack the assembled company with a curtain pole. She eventually dissolved into tears and went to hospital peacefully and apparently gratefuly.

Examination of the house revealed that it was bare of furniture apart from a bench seat and no sign of food apart from the remains of a sliced loaf. No heating of any kind was found, although the temperature had been below freezing point for several days. The patient appeared surprisingly fit considering her deprivations, but she was very dirty. She had visual and auditory hallucinations but settled quickly in hospital as an informal patient. In due course we expect to assist in her rehabilitation.

Case C. The following is a brief case history of a subnormal patient and is given to illustrate the pattern of events at which we aim in our support of the subnormal in the community. The boy concerned obviously could not make the grade at the small village school which he attended from the age of five years, in spite of the advantages of the more individual attention from the teaching staff which he received and which would not have been possible in a school with larger classes. When he reached nearly eleven years of

age he was officially reported under the Education Act as being incapable of receiving education at school and his training and future welfare then became the responsibility of the local health authority. Unfortunately for geographical reasons training centre facilities did not become available until the boy was thirteen years of age. He then entered the old Wigton Training Centre on a full-time basis and during the next three years made considerable progress, particularly in his social adaptation. Too much care cannot be given in the selection of employment in this type of case, but by the patient efforts of the Mental Welfare Officer aided by the Youth Employment Officer and the Disablement Rehabilitation Officer, a job was found which appeared to offer employment within the boy's limited mental ability and well within his physical capacity as a farmhand with an employer who was thought to be tolerant of the patient's limitations and willing to spend time in training and guiding his new employee. A reduced rate of wages was negotiated and agreed between the farmer and the local representatives of the Ministry of Agriculture, Fisheries and Food. This was six years ago and although the patient has an I.Q. in the low 50s he has been entirely successful in his work and is a completely trustworthy and responsible member of the community. At no time has he given the slightest cause for concern, and his social behaviour is of a pattern which could well be followed by his contemporaries. Needless to say the support which we now offer through our mental welfare staff is minimal, consisting only of a very occasional friendly visit to confirm that all still goes well.

Training Centres

(a) For Juvenile Subnormals

The junior training centres at Whitehaven (65 places) and at Wigton (25 places), coupled with the arrangement which exists with the City of Carlisle for the training of the few County children living within easy reach of the City at their Kingstown Centre, continues to meet the demand for the day training of juvenile subnormals at full-time training centres.

I consider that adequate provision for the training of subnormal children should be given highest priority in the development of the mental health services, and it is pleasing to note that we still have no waiting lists for admission to this form of training. This state of affairs could not be reached in an area presenting such difficult geographical problems without the boarding facilities which are discussed later in the report.

Of equal importance with buildings and numbers of places is the approach and the spirit applied to the training. There has been a tendency in the past to regard this type of establishment as a centre in which permanently disabled children are kept occupied, out of mischief or amused. Only within recent times has it been realised that an untapped potential for constructive living exists in those designated "subnormal" and recorded as unsuitable for education within the school system. The child with this handicap goes through the same processes of maturation as the normal child in which experience plays such a large part. Although the rate of development may be slower and the final result limited, we must guard against depriving these chidren of the richest type of experience by confining their activities within too narrow limits. An exciting new field is now opened up as a result of experiment not only in this county but elsewhere, and our concept of training is changing in an endeavour to use new techniques along educational lines.

The use of more modern methods in inadequate space, coupled with the fact that the present Whitehaven centre is a wartime building of limited structural life, have highlighted the need for a purpose-designed replacement there, and I shall recommend that this be included in the capital building programme for 1963-1964. The Wigton centre is small and purpose designed but the plan permits of easy extension. It seems probable that an extra wing may need to be added during the year 1964-1965.

The inclusion of a special care unit for subnormal children with very severe or multiple handicaps will, I feel, require serious consideration in future building plans.

(b) **For Adult Subnormals**

It was hoped that a separate training centre for 50 subnormal adults would be ready for use during 1962, but there have been frustrating delays in acquiring the site selected. This is an ideal location to serve the greatest demand. Negotiations between the owner and the District Valuer have so far been unfruitful, but I hope that shortly a satisfactory conclusion will be reached. Preliminary plans prepared by the County Architect have already received the Ministry's provisional approval.

In anticipation of the adult training centre, a male assistant was recruited to the staff of the Whitehaven Junior Training Centre in June, and this appointment has been a noteworthy success. A

room has been set aside at the junior centre and a number of older boys are now receiving training from a man under conditions more suitable to their age and development. The scope of their activities is restricted by lack of space, both working and recreational, and by the fact that the facilities within the centre as a whole are geared to the juvenile rather than the adult. Nevertheless a more adult atmosphere prevails and augurs well for the future success of a centre designed and equipped especially for adults.

(c) **Parents' Association**

The parents' association which was formed in 1960 under the chairmanship of Mr. Froggatt, the Mental Health Officer, continues to meet monthly at the Whitehaven centre. As was intended at the time of inauguration, this association is now run entirely by the parents themselves, but naturally both teachers and social workers attend the meetings and give their support and advice.

The supervisors of the two training centres make the following comments:—

Miss Macpherson, Whitehaven Training Centre

" Whitehaven Training Centre has developed in many different ways owing to the introduction of new ideas and methods of teaching mentally subnormal children.

One of the most important factors of the centre to-day is the greater freedom allowed to the children, helping them to use their own initiative, helping them to independence and self confidence. I quote a few of the changes—

(a) The abolition of locked doors.

(b) Where possible children allowed free access to toilets with minimum supervision.

(c) Nature walks for all groups, weather permitting.

(d) Children allowed to play outside in centre grounds during the after lunch break.

(e) Senior boys now able to participate in more adult pursuits owing to help and guidance from Mr. Lace, the male member of the staff. Preliminary woodwork lessons, naming, handling and using real tools, football and cricket are now part of the centre's curriculum.

Junior Nursery Group

Education through play is the theme but there is some restriction of activities owing to lack of space in the centre. Visual aids are used wherever possible to give the child a mental picture which he understands. Physical education is progressing favourably, using equipment for normal children (as far as possible), but making allowances for physical handicaps.

Intermediate Group

In this group the training continues at a higher level, with the introduction of number work, simple reading by " look and say " methods, copy writing, money values, etc. It has been a great asset to have a qualified school teacher with this group.

Future Trends

The training of the subnormal is now more educational in outlook and towards this I make the following suggestions:—

(a) There should be a separate nursery class from junior class. If the mental age of a subnormal child is half the chronological age, then a 5 year old is only $2\frac{1}{2}$ years mentally, and should be so managed. These children are still at the stage of development where they need " mothering ".

(b) It is impossible to do justice with mixed groups so that assessing and grading into suitable groups is most important.

(c) The transferrence of all children of 16 years and adults to adult centres."

Miss Lister, Wigton Training Centre

" Looking back over the past ten years of training centre experience, I feel the greatest development has been the increasing opportunity for early admission at the 5 year old stage. I think this has been highly important for natural development, and ultimate future progress in his efforts, and however limited his achievement, gave him the self confidence to try again. In my opinion, this lays a firm foundation for all his future efforts and he is ultimately a more interested and interesting child if he received this training at an early age rather than much later.

Thinking of trends for the future I envisage the necessity for better education of the general public regarding their attitude and approach to these children. Because of ignorance, there is often either apathy or too much sympathy; knowledge would help to strike a balance and in so doing give people a better understanding of the problems and often the feelings of guilt which the parents of these children have to face."

Residential Accommodation

(a) **For the Subnormal**

With a density of population in our administrative area of 0.2 persons per acre, there is a need for residential accommodation for reasons which would never arise in more heavily populated parts of the country. Orton Park, the hostel for juvenile subnormals, was opened in 1959 to enable those children living in the more remote parts of Cumberland to participate in full-time training at a day centre. They are boarded at Orton Park, travel daily to the Wigton Training Centre, and can return home each week-end, or as frequently as is desirable during term time and for the training centre holidays.

Besides this very necessary function, the hostel enables the authority to offer temporary residential care for subnormal children to cover periods of domestic difficulty in their homes. It has also provided the opportunity to study the needs of the young subnormal child—emotional, social and educational—in much greater detail, and our patterns of management and training both at the hostel and the training centre have changed considerably as a result.

From the valuable experiment carried out under the auspices of the Mental Health Research Fund under the leadership of Dr. J. Tizard at Brooklands, we have learned a great deal. The Brooklands experiment has been studied and discussed with the staff of the hostel and training centres and a special film illustrative of the unit's work stimulated lively and progressive discussion when shown to audiences in Cumberland which had an interest in subnormal children.

In October, with the approval of the House Committee, the children resident at the hostel were carefully divided into groups, each containing not more than four or five children, and responsibility for each group was allotted to one housemother. Great

care was taken to distribute the children over the entire age range (6-15 years) as evenly as possible between the groups, with an appropriate mixture of the sexes, and avoiding overloading any single group with children requiring a good deal of personal attention or who present special problems of management. By this means, a "family group" pattern of care is more easily established —the child having a firm mother substitute whilst in the hostel and the housemother a better opportunity of getting to really know her charges.

Miss Graham, Matron, Orton Park, reports:—

"At the beginning of October, 1961, the children at Orton Park were divided into groups of four under the supervision of one member of staff as a mother figure. Now after approximately six months we are beginning to see some results of the scheme. The children are beginning to identify themselves with their particular "mother" in as much as they go to her with their little troubles and delights, instead of coming to my deputy or myself as they did before.

One of the main obstacles that had to be overcome was the rearrangement of sleeping accommodation. Two or three of the children with behaviour disorders at night who were hitherto kept apart, were now having to be put together in the same bedroom. We had a few upsets in the first week or so, but after constant supervision the children settled down and accepted the situation. Meal times seemed to be the least of the problems, as each member of staff had her own family around her at their own table, and there is now a marked improvement in general behaviour at the table.

Considering the fact that a short time ago these children were living as one large group and have now been divided into small units, with the complete co-operation of the staff, the children have accepted the change well, but we do feel that new entrants will accept the scheme completely as they will not have known any other."

One reason for the relatively high unit cost of maintaining this hostel arises from under-occupation during the twelve weeks of training centre holidays when most of the accommodation is vacant. During the summer we were glad to welcome two groups of ten subnormal children from Newcastle for a holiday. Each

group was accompanied by two members of their own training centre staff and stayed for ten days. Picnics and excursions were arranged for them and the sharing of experiences was of benefit both to our staff and the visiting staff. By the end of January, 1962, arrangements had been completed to receive subnormal children from Newcastle and the West Riding of Yorkshire to the maximum capacity of the hostel for the whole of the summer vacation.

In planning future development in this field we have to consider the optimum size of units of accommodation. I suggest that Orton Park with room for 22 children is quite big enough and that if, as seems possible within the next five years, more accommodation of this type is needed, thought should seriously be given to providing another similar unit (somewhere in West Cumberland and allied to a new Whitehaven Centre) in preference to enlarging the Orton Park accommodation.

A natural and inevitable development which will follow the provision of a training centre for adults will be the need for residential accommodation for those whose homes are beyond reasonable daily travelling distance of the adult centre. It may, however, be found possible to arrange for those attending the centre to be boarded out, either singly or in twos or threes, in private households.

(b) **For the Mentally Ill**

Included in the capital development programme for 1962 1963 was a hostel for 25 discharged hospital patients, and later it was decided, in the light of other authorities' experience, to leave the scheme in that year's programme but to reduce it in size to cater for 17 residents.

A special sub-committee, including consultant psychiatrists from the Garlands Hospital and the West Cumberland Hospital and the Regional Welfare Officer of the Ministry of Health, gave careful consideration to the two differing possible functions of such a hostel in relation to social and clinical needs:—

(a) Short stay as part of rehabilitation and a means of temporary support.

(b) Long term for those requiring lengthy rehabilitation or who would be unable to fend for themselves in the community without support.

The report of the special sub-committee was received and the Council decided to defer the scheme for a year but, in the meantime, to take steps to acquire a suitable site.

Hospital Accommodation

(a) **For the Mentally Ill**

The Regional Hospital Board's plans for psychiatric hospitals and units have an obvious bearing on the local authority services. Dramatic changes have taken place in the treatment of mental illnesses during the past few years. This fact, supported by improved facilities for out-patient treatment and a rapid build-up of community care services, have resulted in a substantial decline in the overall demand on psychiatric beds. The policy of developing short-term psychiatric units in general hospitals will, it is hoped, help ultimately in reducing the demand for accommodation for long-stay cases, and it is forecast nationally that in 15 years' time the total bed requirements for in-patient treatment of the mentally ill will be nearly halved. It is quite clear that our contribution as a local health authority must be to make every effort in providing supportive services within the community, in the first place to prevent the need for hospitalisation, and secondly to speed the return to the community of those patients who for some reason or other need a form of treatment which can only be given in hospital.

Locally the number of beds available for psychiatric cases in the West Cumberland Hospital was increased from 16 to 28 in 1961, and we look forward to the opening of the new admission unit and convalescent villas at the Garlands Hospital, which will provide an additional 110 beds in the early summer of 1962.

Dr. Begg has now taken up his appointment as Medical Superintendent of Garlands Hospital and already he has shown, like his predecessor Dr. Braithwaite, a very welcome enthusiasm in co-operating to the full with the local authority mental health services. I would like to welcome Dr. Begg and I look forward to our continuing co-operative efforts along with all of his psychiatric colleagues.

A new development in the hospital psychiatric service in West Cumberland has been the commencement during 1961 of a child psychiatric clinic run by Dr. Gibson. This was discussed very fully from the point of view of its effect on the child guidance clinic run in West Cumberland by Dr. Ferguson and it was agreed that both types of clinic should run concurrently for a period with

provision for the inter-change of patient between the clinics where appropriate.

(b) **For the Mentally Subnormal**

The picture as regards hospital accommodation for the mentally subnormal is by no means so optimistic. Nationally the demand for beds for higher grade patients has fallen off, no doubt in large measure due to more adequate provision for the training and care of the subnormal within the community, but there continues to be an increasing demand in respect of lower-grade patients. This, I suggest, arises mainly for the following reasons:

(a) The fact that practically all lower-grade patients require hospital care for a very long time and possibly throughout life so that there is little "turn-over" of such patients within any particular hospital.

(b) A greater proportion of grossly handicapped babies are surviving beyond infancy.

(c) The increased expectancy of life of such lower grade subnormal patients.

The waiting list for beds in psychiatric hospitals for the subnormal at the end of the year was:—

		Male	Female	Total
Subnormal—				
Under 16	...	—	—	—
16 and over	...	1	—	1
Severely Subnormal—				
Under 16	...	4	1	5
16 and over	...	12	21	33
		17	22	39

Numerically this total is very little different from last year's figure, but fortunately none of the patients included in the list are regarded as being in urgent need of hospital care. All are at present adequately catered for (with occasional support provided by short periods of hospital or hostel care) in their own homes, and they represent those subnormals who will ultimately require the type of care or nursing which is at present available only under hospital conditions.

Short-Term Care (Circular 5/52)

This provision of temporary care away from home for the mentally subnormal rarely presents any difficulty in Cumberland. A very wide range of need from the sudden illness of the mother to the simple arrangement of hostel care for the patient to enable the family to take a holiday can usually be managed. Thanks largely to Dr. Ferguson's continuing and enthusiastic co-operation, Dovenby Hall Hospital is able to take patients who require medical or nursing care, and our hostel at Orton Park can cope with ambulant, trainable children quite easily during training centre holiday periods. The following table shows the use of this scheme during 1961.

		Admissions	...Patient days
Dovenby Hall Hospital	...	45	2394
Orton Park	...	27	741
		72	3135

Social Centres and Clubs

Circular 9/59 of the Ministry of Health, which suggested a framework on which local health authorities' mental health services should be developed, recommended that social centres should be established " to provide a meeting place where members can acquire increased confidence in themselves and in their ability to make contacts with others ". Experience in this form of help is limited—the majority of clubs are new enough still to be regarded as experimental—but pioneering efforts throughout the country to date provide enough evidence to justify the development of centres and clubs.

Whether the centre is organised in the first place by the psychiatric hospital or by the local health authority, it should be actively supported by both, and steered along lines which will enable it to be run by its members in due course. I feel that there is a greater need for **social** clubs (having an indirect but undoubted therapeutic value) than for **therapeutic** clubs whose locale is probably better in the day hospital or pre-discharge unit of the psychiatric hospital itself.

In spite of the practical difficulties which exist in an area such as Cumberland due to sparsity of population and the cost of transport, the social club for former patients of the psychiatric unit of the West Cumberland Hospital which is held in the junior training centre at Whitehaven on Wednesday evenings, continues to

flourish. This is due in large measure to the continuing enthusiasm of the secretary and executive (club members) and to the active support of the social workers both from the local health authority and the hospital. Towards the end of the year, one of my mental health workers pointed out the desirability of providing a daytime social centre, particularly for those former hospital patients who could occupy themselves with domestic duties in the morning and who had company (or responsibilities for children) within the home during the evening but who found themselves at a loose end during the afternoon. The consultant psychiatrist (Dr. Gibson) supported the suggestion and confirmed that in his experience the fact that relatives sometimes complain of having patients " under their feet " all day makes for increased domestic tensions which may result in demands for re-admission to hospital. The proposition was discussed with representatives of the Women's Voluntary Services and an afternoon club is now held on two afternoons each week in the lecture room at Flatt Walks Clinic, Whitehaven. Members of the Women's Voluntary Services attend on rota to help with the supervision of the meeting and to foster the spirit of social intercourse between the members.

East Cumberland has an even lower density of population than West Cumberland, but I am looking into the possibility of establishing a social club, possibly in conjunction with the Medical Officer of Health for the City of Carlisle, and located within the city, which county residents living within reasonable travelling distance could attend.

Training and Recruitment of Staff

Patterns of staff training already approved by the Council have continued throughout the year and have paid good dividends.

We were glad to welcome Mr. Mayoh on the successful completion of the Council's first scholarship course for the training of psychiatric social workers. He now serves as senior mental health worker in the East Cumberland area, taking a limited case load of patients demanding support of the kind for which his more specialised training is appropriate and undertaking supervisory work in relation to the other mental welfare officers in that part of the county. Because the lists of applicants for this type of training was greatly in excess of university places available, Miss Welch (Mental Welfare Officer) was unable to take up the scholarship during the academic year 1961/1962, but I am glad that Manchester University have offered her a place for the course beginning in October, 1962.

Miss Macpherson returned in July, after completing the diploma course of the National Association for Mental Health for teachers of the mentally handicapped, and was appointed supervisor of the Whitehaven Junior Training Centre as from the beginning of the Christmas term. Miss Lister returned to Wigton to resume her supervisorship of that junior centre. This means that the supervisors of both our junior training centres have completed the best form of training which is at present available.

One of the assistant supervisors from the Whitehaven Centre (Miss Love) was seconded under the Council's scheme to a similar course which commenced in Sheffield in September.

A sub-committee of the Standing Advisory Committee of the Ministry of Health (under the chairmanship of Dr. Scott) has been looking into the whole question of the training of staffs in training centres for the subnormal, and we look forward to progressive development resulting from its report.

No special form of training is available for the staffs of mental health residential establishments, although, as demand grows, the National Association for Mental Health proposes to consider arranging suitable courses. It is for this reason that a short inservice course on child development and various aspects of the care of subnormal children was held at Orton Park in the spring of 1961. The course followed the syllabus printed in my last report, and consisted of nine talks followed by free discussion. I am indebted to the speakers for the enthusiasm with which they entered into this new training venture. The lectures, together with my summary of the entire course on the aims and future trends in this type of work, were published in precis form for the guidance of the staff. I hope to supplement this course in the early part of 1962 by a series of talks with more specific reference to the aetiology of subnormality.

We are fortunate in gaining places for two of the assistant housemothers in a refresher course for the staffs of Child Care Services run by the Central Training Council on Child Care for the Home Office. This residential course is of nearly three weeks' duration and will give special consideration to the needs of backward children.

Staff meetings are held at regular intervals throughout the year (a) for mental welfare officers and (b) for the staffs of the training centres and the hostel. They are informal in character

and provide an opportunity to exchange ideas, to keep abreast of changing trends and generally to discuss the development and improvement of the service provided. Recently it has been thought worthwhile to arrange fortnightly seminars for the mental welfare officers to discuss individual cases which present unusual social work problems, and I hope that this will prove fruitful and a means of using in a tutorial fashion the more specialised training in social work of the Senior Mental Welfare Officer.

The training of mental and social welfare officers has been under active consideration for a considerable time, and the emphasis on care of the mentally disordered within the community has highlighted the pressing need for the provision of training facilities to a nationally agreed standard. A National Council for Social Work Training is to be set up (as recommended by the Younghusband Report) which will decide upon a syllabus of training and set examination standards for a basic qualification in social work.

Even after these plans are laid by the National Council, difficulties will remain for some time since there will obviously be a gap in time before the newly trained personnel are available and many local authorities feel that there is much to be said for the early establishment of a short training course for many workers already in the field upon whom will depend the maintenance of the services during the next few years.

Suicide

Suicide and attempted suicide ceased to be criminal offences when the Suicide Act, 1962, became law in August. The need for psychiatric investigation following suicidal attempts, and the co-operation which is essential between the hospital, general practitioner and local authority services in such cases, coupled with the fact that in 1959 the suicide rate for Cumberland (at 59 per million population) was approximately half that of England and Wales as a whole (115 per million population) prompted me to undertake a survey of suicide in the administrative county covering the ten years 1951/1960. This will involve a great deal of detailed investigation and in this Mr. Froggatt, the Mental Health Officer, and Mr. Mayoh, the Senior Mental Welfare Officer, are at present engaged. I must also thank the Coroners, Mr. Pickles and Mr. Gough, without whose generous help and courtesy the study would have been impossible.

SECTION 29

HOME HELP SERVICE

No. of home helps accepted and enrolled on the register at 1st January, 1961	229
No. of home helps accepted during the year	45
	274
No. of home helps resigned during the year	36
No. of home helps on register at 31st December, 1961 ...	238

Districts in which the home helps reside:—

	1961	1960	1959	1958	1957
Alston	11	12	12	11	10
Aspatria	13	16	13	15	18
Border Rual	44	41	44	45	44
Cockermouth	4	4	3	2	3
Ennerdale	31	31	31	31	24
Keswick and Threlkeld	7	5	6	7	6
Maryport and Dearham	13	9	10	12	16
Millom	22	19	19	15	16
Penrith and Penrith Rural ...	26	25	25	26	27
Silloth and Mawbray	9	12	10	13	13
Whitehaven and Distington	18	17	19	13	14
Workington	25	24	25	22	19
Wigton and Fletchertown	15	14	10	17	16
	238	229	227	229	226

Householders—	**1961**	**1960**	**1959**	**1958**	**1957**
No. of applications received for home helps	536	504	447	455	469
No. cancelled or not supplied ...	179	175	152	175	187
No. of new cases helped	333	313	270	268	264
No. of cases on books, 1st January, 1961	544	509	454	414	342
Cases pending	24	21	18	17	18

Analysis of cases helped—	**1961**	**1960**	**1959**	**1958**	**1957**
Confinements	57	60	45	45	56
Tuberculous cases	9	13	12	10	11
Old age and infirmity	505	492	421	391	329
Mental health	2	—	1	3	1
Cardiac	81	62	53	56	48
Blind	30	28	29	22	28
Cancer	7	4	7	5	1
Illness of long duration (cerebral haemorrhage, rheumaroid arthritis, etc.)	115	98	91	91	81
Illness of short duration (post operative, influenza, etc.) ...	71	65	65	59	51
	877	822	724	682	606

In each area meetings of home helps are held at which problems are discussed. In addition visits have been paid as follows:

To home helps	1821
To householders	1469

As will be seen from the above figures there is an increase of 55 in the households which have been helped this year, the majority of which fall into the category of old age and infirmity or illness of long duration. The help that the nurses and health visitors have given in the visiting of the householders and home helps has been invaluable, and has helped to keep a closer contact with the households.

Meetings of home helps were held during the year at the following six centres:—

Alston	Penrith
Carlisle	Silloth
Millom	Whitehaven

At these meetings filmstrips were shown in connection with the work followed by tea and discussion both on the work and personal difficulties. As Cumberland has many rural areas it is felt that the meetings help the administrative staff to appreciate local problems and needs, particularly in placing the right home help in the right household. It is hoped that following these meetings the home helps feel the vital part they play in the health service.

In the future it is hoped to use the home help service to aid in the prevention of break-up of families. The type of circumstances in mind are where the mother of a large family has to be taken into hospital for a short period. Relations often help out but find looking after perhaps two families of small children more than they can manage. It is also hoped to prevent children being placed in children's homes or foster homes.

The introduction of new time sheets has proved to be most helpful. The district nurses and health visitors have been asked to visit the home helps while they are working at the households and if everything is satisfactory the time sheets are then signed. This method helps to keep the central office informed of any alterations that may be necessary, both in the time allowed at each household and the general working arrangements.

A large part of administrative time is spent in dealing with all the correspondence which flows in daily concerning both the home helps and the households they attend. It is pleasing to record that there are only few personality conflicts, and these are

usually settled by a visit from one of the administrative staff. Sometimes a strong line has to be taken when householders feel they need more help than is justified. An application was recently made for the service of a home help when the householder was actually going out to work.

It can easily be seen how difficult this service is to run efficiently and economically, especially in rural districts where travelling times and travelling expenses can be quite considerable. It is also a service of great personal value to many, especially to old people when it enables them to live in their own homes as long as possible. One couple was married at the age of 55 and 62 from a residential home. Their difficulties were many as one partner had no legs and the other suffers from rheumatoid arthritis. This couple were very anxious to have a home of their own and so bought a bungalow. After various alterations were made to the bungalow and they were provided with the loan of wheel chairs, some of their difficulties were solved. They are now both very happy living as full a life and as normal a life as is possible in their own home, but it would have been an impossible undertaking without the services of a home help.

WELFARE SERVICES

The year 1961 has proved a very significant year in the history of the welfare services in the County. It marked the retirement of Mr. Walker, County Welfare Officer, after 31 years of able and devoted service to the County.

The withdrawal of Alderman Douglas from County Council responsibilities, and the untimely death of Mr. Gilbertson in the early part of the year, resulted in the election of Mrs. Cain, O.B.E., as Chairman of the Welfare Sub-Committee, with Mr. McCarron as Vice-Chairman.

The report of the Working Party on the care of the elderly in the County, published in 1959, foreshadowed the ultimate integration of the Welfare Department with the Health Department, and it was decided by the Council that the time was opportune to give effect to this policy. As from the 1st November, 1961, the County Medical Officer assumed responsibility for the welfare services, the staff of the former Welfare Department now constituting the Welfare Section of the Health Department under the administrative control of Mr. Hodgson, previously Deputy County Welfare Officer, as Welfare Services Officer.

I feel sure that this arrangement can be made to operate with substantial mutual advantage to the Health and Welfare Services, and it is my intention to integrate thoroughly at all points of contact the excellent work which I find being done in welfare, with the other services, particularly the nursing service, of the department. Already by the end of the year I have made every effort to introduce the nursing and appropriate administrative staff of the Health Department to the staffs of the residential homes. Outstandingly, in the matter of the care of the elderly, which daily assumes increasing importance in the work of the department, am I confident that the Health and Welfare services must and will function smoothly with a single purpose. In other aspects of the work also, for example, liaison with the School Health Service in the matter of handicapped children leaving school, and in the medical aspects generally in the care of the handicapped, I look forward to a close co-operative approach which must ultimately benefit the individuals dependent on our services.

I would like to deal at a little greater length with the largest single task of the welfare section, namely, the important part which

it must play in providing for the continuing happiness and sense of usefulness in the lives of old people. This, of course, largely centres on their homes.

Homes for Elderly People

It is clear that the primary need of ageing people is that of a secure and comfortable home which meets the wishes and needs of the individual.

It is equally clear that for the majority of old people this involves every effort being made to ensure that the individual is able to retain and enjoy the peculiar personal comforts and satisfactions of his or her "own home" for as long as is humanly possible and compatible with health and fitness to manage a house. This is undoubtedly conducive to a maximum sense of independence and significance in the community for elderly people. In this connection the combined services of the whole of the Health Department, together with the invaluable work done by voluntary bodies, have a potential which should be able to transform the pattern of old age when compared with past years. It must not be forgotten that each elderly person is an individual whose own wishes with regard to all aspects of his or her life are paramount and the services offered to them must in all cases be based upon sound and happy personal relationships with the workers involved. The latter must necessarily cultivate a real flexibility of approach and in most cases provide the services required quite unobtrusively.

The Health Visitor is increasingly assuming responsibility for a general background supervision of as many elderly people as possible. This work must obviously be selective and depend upon the circumstances of the individuals. The home nursing and home help services can similarly be harnessed at a moment's notice, and again I would like to emphasise how high a value I place on the work done by the Old People's Welfare Committees in the County and the "Friends" organised by the Women's Institutes. Their easy and smooth liaison with the Local Authority services is, I am sure, one of the important keys to the happiness and welfare of the old people who so gratefully receive their ministrations.

The day inevitably arrives when an old person is unable to manage entirely independently his own home, or feels the burden increasingly heavy. It is at this point that the great value is to be seen of the modern concept of what has come to be called "Partial

Dependency Dwellings". Here grouped flatlets or bungalows are erected by the Housing Authority and in conjunction the County Council as Welfare Authority finance the erection and maintenance of a block which contains communal lounges and accommodation for a Warden whose personal suitability for the friendly and helpful supervision of the residents in the houses is an outstandingly important factor in the success of such a scheme. The first such scheme in Cumberland was opened on the 18th December, 1961, at Derwent Close, Keswick. Here there are 10 ground floor and 10 first floor flatlets with the communal block featuring as a wing of the building. The outlook of the windows of the lounge, and to some extent also of the flatlets themselves, will in due course be directed on to the main Market Square of the town, when certain old intervening buildings have been demolished. I feel I can do no better than insert at this point the comments of the Warden, Mrs. Tyson:—

> "There is a widespread need for accommodation in which elderly people can live and look after themselves and yet not be cut off from the community. Derwent Close flatlets are the ideal type of dwelling to meet this need. After three months of living here, we find that all the tenants are extremely comfortable and happy, and enjoying what we think is the greatest asset of this scheme, namely, their independence. Everything so far is running smoothly, and the general feeling is of "not wanting to give any trouble". However, knowing that they can summon the warden by ringing their bell, in any kind of emergency, and by having neighbours about them all the time, they have a feeling of security which they did not have, when living, for example, alone in a cottage.
>
> The central heating is a great boon, giving comfortable warmth without the worry of coal fires. An advantage too is the central position of the building, so near to the shops, and to relatives and friends. The tenants cope quite ably with their cooking, shopping and housework, apart from two who make use of the "home help" service.
>
> The communal room, with its comfortable chairs, coal fire and television set, is a popular meeting place, and used by the majority some part of the day. A "get together" is organised by the Warden and some of the younger tenants once a month, and everyone can bring a friend for afternoon

tea in the communal room. The ages of the tenants range from 65 years to 92 years, and these flatlets help them to lead a useful and active life."

I am glad to be able to say that other similar schemes are planned and expected to go forward in 1962, namely, at Brampton, Dalston, Wigton, Penrith and Cockermouth.

A very interesting variant of this scheme is being planned for Alston where the geographical situation of that small community suggested the erection of a small residential home linked physically and functionally to a small group of partial dependency dwellings. It is also proposed that the social and domestic life of the two arms of this provision might well be securely consolidated together. It is suggested that the Matron of the home also function as Warden of the bungalows and so provide a more comprehensive provision for the elderly of this area, who so naturally show a great reluctance to move to another area in their declining years. One of the most significant aspects of this scheme in my opinion is the very gratifying evidence which it gives of the strength of the co-operation between Housing Authorities and the County Council as Welfare Authority. Similar arrangements may well prove suitable for certain other small but distinctly individual communities in the County.

The aspect of the welfare services which is at present receiving perhaps more detailed thought and consideration in the department than any other, is the future pattern of the provision of residential homes for old people. Already an excellent start has been made in Cumberland in the provision of new modern type small homes. The first of these (for 38 people) was opened in Maryport in May, 1960, and two further small homes, one at Egremont and one at Workington will be completed by the end of 1962. The County Council has recognised for some time that the accommodation offered at Meadow View House, Whitehaven, the old Public Assistance establishment, was out of tune with modern requirements altogether. At the time of writing this report, it has been decided that the opportunity provided by the opening of the two new homes in West Cumberland should be taken to close Meadow View House. This is, in my view, an important step forward and I expect to give some account in my Annual Report next year of the far from uncomplicated exercise involved in eliminating this establishment which has had a maximum of accommodation for 110 residents, and which is also of course a joint user establishment with the Hospital Management Committee.

One of the lounges at Parkside, Maryport—A new type home

The other two joint user establishments in the County, namely, Highfield House, Wigton, and Station View House, Penrith, offer a higher standard of accommodation for those in need of care and attention (National Assistance Act, Part III), though even their days must be regarded as numbered in the forward planning of accommodation. Plans are being prepared at present for a home of 20 to 25 beds in Brampton, which in itself underlines a further important principle in planning this type of provision, namely, what I feel is appropriately called "neighbourhood care".

I think it is of immense importance that the maximum of neighbourhood care should be provided for old people who require residential accommodation in such a home. This will tend to make for a larger number of smaller homes more widely distributed in a County like Cumberland, with perhaps some increase in the expense, but I am sure that it is in the modern concept of up-to-date services for the elderly.

The increasing average age of the population and the implications of what has come to be called "medicated survival" is

now beginning to throw into relief the need for special accommodation for the very infirm elderly who, though not requiring hospital accommodation with nursing care, nevertheless require a greater amount of care and attention than the majority of residents in old people's homes. I envisage the inclusion of such a home probably in West Cumberland in the building programme within the next 5 years.

It will be seen then that quite a wide variety of different types of provision is contemplated to ensure a " home " in the truest possible sense of the word for all the old people in the County. I feel sure that Authorities will accept the necessary expenditure on these schemes as the fulfilment of one of the most pressing social requirements of our day.

The Towers, Skinburness, has provided holidays during the year for 171 persons from other establishments and from their own homes. There are in this dual purpose home a few permanent residents who formerly lived in Silloth or the surrounding district.

The proportion of old people will, within the next decade, rise from 1 in 7 to 1 in 6 of the population. It is estimated that places in Part III homes will have to be provided on the basis of 2 per 1,000 of the total population within the next five years, and on this formula beds will be required as follows to meet actual needs:

Population (1961)	Estimated number of beds required	No. of beds available (excluding Meadow View House and the holiday home at Skinburness)	No. of beds to be provided under approved schemes	Estimated deficiency
233050	446	230	96	120

It is an interesting feature that with the new purpose built homes, married couples can be admitted and continue to live together.

I think the following table shows very closely the trend towards the increasing use of modern type homes:—

Available Beds and Occupancy — Comparative Statement

At 31st December	No. of Beds provided			No. of Residents		
	Joint User Establishments	Modern Type Homes	Total	Joint User Establishments	Modern Type Homes	Total
1949 ...	375	—	375	235	—	235
1950 ...	375	—	375	238	—	238
1951 ...	325	—	325	243	—	243
1952 ...	325	—	325	217	—	217
1953 ...	325	19	344	201	18	219
1954 ...	325	19	344	219	19	238
1955 ...	263	69	332	188	57	245
1956 ...	263	69	332	189	70	259
1957 ...	242	69	311	188	65	253
1958 ...	242	87	329	193	88	281
1959 ...	252	108	360	199	99	298
1960 ...	215	146	361	174	132	306
1961 ...	215	146	361	178	132	310

The following two tables show the admissions during the year, and the pattern of beds available in the modern type homes:—

Admissions during year ended 31st December, 1961

	New Admissions	Transfers from other Homes	Re-admissions after holiday or from hospital
Station View House ...	17	1	8
Highfield House ...	14	—	19
Meadow View House ...	50	9	49
Derwent Lodge ...	1	2	8
Garlieston ...	2	2	11
The Towers ...	10	6	2
The Croft ...	2	3	6
Parkside ...	17	4	3
Grange Bank ...	7	3	1
Totals ...	120	30	107

Table of Available Beds and Age Groups in Modern Type Homes

Home	No. of Beds					AGE GROUPS OF RESIDENTS												
						MALES						FEMALES						
	4 bedded rooms	3 bedded rooms	2 bedded rooms	Single rooms	TOTAL	Under 60	60—70	71—80	81—90	Over 90	TOTAL	Under 60	60—70	71—80	81—90	Over 90	TOTAL	Total No. of Residents
Grange Bank, Wigton— Opened 1.4.53.	12	6	—	1	19	—	—	—	—	—	—	2	2	3	10	2	19	19
Derwent Lodge, Papcastle— Opened 1.1.55.	8	6	4	—	18	—	2	10	1	1	14	—	—	—	—	—	—	14
Garlieston, Whitehaven— Opened 1.11.55.	12	18	—	2	32	—	—	6	8	2	16	—	2	4	8	—	14	30
The Croft. Kirksanton— Opened 1.3.58.	—	6	10	2	18	1	2	4	—	—	7	—	2	3	6	—	11	18
Parkside, Maryport— Opened 16.5.60.	—	—	18	20	38	1	4	6	2	—	13	2	2	11	7	1	23	36
The Towers, Skinburness— Opened 1.8.58.	12	—	8	1	21	(—	—	4	—	—	4	—	—	5	4	—	9	13)
						(—	—	—	1	—	1	—	—	1	—	—	1	*2)
Totals ...	44	36	40	26	146	2	8	30	12	3	55	4	8	27	35	3	77	132

Temporary Accommodation

The erection of a building within the grounds of Highfield House, Wigton, giving accommodation for three family units, was completed during the year. The primary purpose of this accommodation was the temporary housing of problem or evicted families to contribute towards the prevention of the break-up of such families. In fact it has not been necessary to use the accommodation for this purpose since it became available, and I think that consideration may need to be given to an alternative use for it.

Persons Without a Settled Way of Living — Calthwaite Reception Centre

During the twelve months to 31st December, 1961, 2342 men and women passed through the Centre, an increase of 4 persons over the previous year. 94 persons were placed in employment. The decline in admissions during 1959 (2959) which was maintained in 1960 (2338) has halted in 1961 (2342).

Registration of Disabled Persons' or Old Persons' Homes

There were no new registrations effected during the year, but in accordance with the National Assistance (Numbers in Homes) Regulations, 1961, the number of people to be accommodated were restricted in the three homes already registered, viz.:—

Seaton Villa, Seaton	... ...	8 persons
Stoneleigh, Gosforth	... ...	11 persons
Rothersyke House, Egremont	...	10 persons

Regular inspections are carried out.

Handicapped or Disabled Persons

The Workington Centre and Social Club for Handicapped Persons was informally opened on the 18th November, 1961, by Alderman Mrs. E. G. Cain, O.B.E., Chairman of the Health Welfare Sub-Committee. The Rector of St. Michael's Church, Workington, who was present, offered a short prayer of dedication.

It is already clear that this Centre will meet a real need in the most populous area of the County, and the Social Worker/Craft Instructor in charge, Mr. Robinson, is doing everything possible to ensure the use of the Centre to the maximum advantage of the handicapped groups.

The deaf have particularly welcomed the use of this building which, after a long break, has resulted in a resumption of their community social life in West Cumberland.

The premises are also used by the Blind Association on two days a week, and classes for the instruction of the general class of handicapped people are also a regular feature.

It is also becoming increasingly apparent that there is a need for a residential home for younger severely handicapped people. There is some provision for this group in some parts of the country under the auspices of National voluntary bodies, but there is a great deal to be said for a local home in an area like Cumberland to accommodate and meet the needs in a comprehensive fashion of the County's younger severely disabled people. Such a project I hope also to include in the capital programme within the next 6 years.

Blind, Partially Sighted and Deaf

The Cumberland and Westmorland Home and Workshops for the Blind and the Barrow, Furness and South Cumberland Society for the Blind, have continued to act as the Committee's agents in the administration of welfare services for the blind in their respective area. The Carlisle Diocesan Association for the Deaf act as agents for social services for the deaf.

Half yearly reports on the services carried out by these voluntary associations are submitted to the Welfare Sub-Committee.

Blind and Partially Sighted
New Registrations

During the twelve months to the 31st December, 1961, 64 persons were certified as blind and 19 as partially sighted, age group classification being as under:—

Blind	0-4	5-10	11-15	16-20	21-39	40-49	50-64	65 years & over	Total
Males	—	—	1	—	—	1	6	23	31
Females	1	1	—	—	—	—	3	28	33
	1	1	1	—	—	1	9	51	64
Partially Sighted									
Males	—	1	2	—	2	—	1	4	10
Females	—	—	—	—	—	1	—	8	9
	—	1	2	—	2	1	1	12	19

It will be noted that 10 blind and 4 partially sighted persons came within the working age group, viz.:—16/64 years. Generally speaking, it was found, after investigations, that—

(a) women were not available for employment; and

(b) the men were incapable of and unsuitable for employment in open industry.

Numbers on Register at 31st December, 1961

The total number of blind and partially sighted persons registered on the 31st December, 1961, are classified as follows:—

Age Group	Blind			Partially Sighted		
	M.	F.	Total	M.	F.	Total
0— 1 ...	—	—	—	—	—	—
1— 4 ...	1	1	2	—	—	—
5—10 ...	3	3	6	3	—	3
11—15 ...	3	1	4	8	3	11
16—20 ...	3	—	3	5	3	8
21—29 ...	6	2	8	—	2	2
30—39 ...	14	6	20	3	1	4
40—49 ...	14	13	27	3	5	8
50—59 ...	23	20	43	8	5	13
60—64 ...	15	23	38	5	5	10
65—69 ...	23	42	65	2	8	10
70 and over . .	110	198	308	21	40	61
	215	309	524	58	72	130

16 County blind persons are employed in the Workshops, 5 of whom reside in the hostel.

Handicraft classes have been held through the year at Penrith, Whitehaven, Egremont, Workington and Millom.

Deaf

The following analysis of registered deaf persons in the Administrative County is given:—

School age or under	24
In Institutions	1
In Mental Hospitals	6
In full-time employment	52
Married women at home	17
Single women at home	3
Unemployed—age	9
Unemployed—infirmity	6
Unemployed	2
Private means	1
	121

Voluntary Services

I have already made reference to the work of the numerous voluntary bodies who expend so much devoted energy in the welfare of just those groups of people who are in varying degrees our mutual responsibility. Some, as has been mentioned, operate under an agency arrangement, while with others the services arranged are complemetary to the work of the Health and Welfare Department. Outstanding amongst the latter is the Cumberland Old People's Welfare Committee, whose West Cumberland branch has so very appropriately as Chairman, Mrs. Cain, O.B.E., Chairman of the Welfare Sub-Committee of the County Council. It is very gratifying to see how fully the need for close liaison has been appreciated at all levels. At the time of writing this report, an appointment is being made by the Old People's Welfare Committee of a Social Worker in West Cumberland, of which the main financial support will be a special grant from the County Council. His or her duties will centre on the stimulation of the formation of more local Old People's Welfare Committees in the West of the County in particular. During 1961 the Old People's Welfare Committee

organised an "Old People's Week" which very successfully portrayed the work of statutory bodies such as the County Council and the Regional Hospital Board alongside the services of the Committee. During the week an "Open Day" was held at all the County Council homes. Very satisfying reports and comments were forthcoming from many of the visitors.

The groups of "Friends" arranged by Women's Institutes have, as I have indicated, an important and very helpful role to play, particularly in the welfare of old people still living in their own homes, and in this same connection the quite invaluable services of the W.V.S. in providing a Meals on Wheels service in Workington, Whitehaven and Millom, claims honourable mention. I am confident that we shall increasingly work with these excellent bodies and I would like to record my own sense of good fortune in administering the County Health and Welfare services in such a favourable climate of mutual helpfulness.

GENERAL PUBLIC HEALTH

Infectious Diseases

Inspection and Supervision of Food

Water and Sewerage

Housing

Caravans

	Scarlet Fever.	Whooping Cough.	Ac. Pollomyelitis Paralytic.	Non-Paralytic.	Measles.	Diphtheria.	Dysentery.	Meningococcal Infection.	Acute Pneumonia.	Smallpox.	Acute Encaphalitis Infective.	Post Infectious.	Enteric or Typhoid Fever.	Paratyphoid Fever.	Erysipelas.	Food Poisoning.	Tuberculosis Respiratory.	Meninges and C.N.S	Other.	Puerperal Pyrexia.	Ophthalmia Neonatorum
URBAN DISTRICTS —																					
Cockermouth ...	—	—	—	—	17	—	6	—	—	—	—	—	—	—	—	2	—	—	—	—	—
Keswick ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Maryport ...	7	6	—	—	295	—	3	—	7	—	—	—	—	—	—	1	9	—	—	—	—
Penrith ...	8	—	—	—	32	—	82	—	1	—	—	—	—	—	—	2	8	—	1	1	—
Whitehaven ...	3	4	—	—	76	—	—	—	1	—	—	—	—	—	—	—	13	—	4	1	—
Workington ...	7	2	3	—	181	—	5	—	36	—	—	—	—	—	3	—	9	—	3	17	—
RURAL DISTRICTS—																					
Alston ...	—	—	—	—	151	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—
Border ...	10	1	—	—	571	—	9	—	2	—	—	—	—	—	—	1	7	—	2	—	—
Cockermouth ...	3	1	—	—	161	—	20	—	11	—	—	—	—	—	3	—	4	—	—	1	—
Ennerdale ...	2	27	1	—	175	—	1	—	9	—	—	—	—	—	—	—	17	—	2	1	—
Millom ...	3	31	—	—	340	—	7	—	7	—	—	—	—	—	2	5	5	—	—	—	—
Penrith ...	11	—	—	—	71	—	8	—	1	—	—	—	—	—	—	1	2	—	1	—	—
Wigton ...	3	—	—	—	134	—	8	—	8	—	—	—	—	—	2	3	5	—	1	—	—
TOTAL FOR YEAR ...	57	72	4	—	2204	—	149	—	85	—	—	—	—	—	10	15	80	—	15	21	—
1960 ...	114	392	—	—	1999	—	35	2	83	—	—	1	—	—	6	95	126	1	16	9	—
1959 ...	254	153	—	—	3363	—	21	1	90	—	1	—	2	1	13	56	127	2	16	47	3
1958 ...	115	28	4	1	349	—	187	5	60	—	—	—	—	—	12	11	155	4	23	30	2
1957 ...	25	661	11	4	3557	—	20	5	182	—	2	1	—	—	19	28	186	2	32	44	2

INSPECTION AND SUPERVISION OF FOOD

I am indebted to the Chief Inspector of Weights and Measures for the following report:—

Food and Drugs Act, 1955

Summary of work done under the above Act during the year ended 31st December, 1961

	Total Samples Obtained		Genuine		Unsatisfactory	
	Milk	Other Foods	Milk	Other Foods	Milk	Other Foods
Submitted to Public Analyst ...	31	233	15	228	16	5
Tested by Sampling Officers ...	422	—	399	—	23	—
	453	233	414	228	39	5
	686		642		44	

Milk

31 samples of milk, including 9 " appeal to cow " samples, were submitted to the Public Analyst during the year. Adverse reports were received on 16 of the samples.

Of the 422 samples of milk tested by the sampling officers and not submitted to the Public Analyst, 23 were found to be slightly below standard. In such instances further samples were taken later to see that the quality had improved.

The presumptive standard for milk, other than Channel Islands quality, is 3.0 per cent. fat and 8.5 per cent. solids-not-fat. The average quality of the samples tested by the sampling officers was 3.64 per cent. fat and 8.68 per cent. solids-not-fat. These figures show a slight increase when compared with last year's figures; that of 0.1 per cent. fat and 0.02 per cent. solids-not-fat. These averages do not include the results of analyses by the Public Analyst, but they do include the samples tested by the sampling officers which are found to be slightly below standard.

Of the total number of milk samples taken, the percentage of unsatisfactory samples was 8.6 per cent., a decrease of 0.8 per cent. when compared with the previous year's figure.

The 16 milk samples certified by the Public Analyst to be unsatisfactory were dealt with as follows:—

Five of the samples contained added water for which two farmers were prosecuted. One case was in respect of two samples containing 5.5 per cent. and 7.4 per cent. extraneous water and the second case concerned three samples with added water ranging from 34.8 per cent. to 43.0 per cent. Fines of £10 and £40 were imposed respectively, plus £4 4s. costs in the latter case.

A dairyman was prosecuted for selling ordinary milk as Channel Islands milk (2 samples) and was fined £25 plus £5 5s. costs. Channel Islands milk should contain 4.0 per cent. fat as compared with 3.0 per cent. for ordinary milk.

A farmer was cautioned in respect of two samples containing extraneous water. The circumstances in this case did not warrant proceedings being taken.

Six samples, although of genuine quality, were found to be sub-standard and the producers concerned were advised to take steps to improve the quality of the milk to bring it up to the required standard.

A sample of Jersey milk (standard — 4.0 per cent. fat) was found to be deficient in fat content and the dairyman concerned was cautioned.

Foodstuffs Other than Milk

A total of 233 samples of various foodstuffs and drugs were taken during the year and 228 were found to be genuine and 5 unsatisfactory, a percentage of 2.15.

The 5 unsatisfactory samples consisted of an orange drink, epsom salts, tinned raspberries, sausages and a mixture for making iced lollies.

The orange drink was certified by the Public Analyst to be incorrectly labelled, the claim for the amount of fruit present not being justified. The manufacturers agreed to have new labels printed.

A sample of epsom salts was found to contain some discoloured crystals and did not conform to the B.P. limit test for iron. The sample was taken from old stock which was withdrawn from sale. The manufacturers were also notified and they instructed their representatives to advise shopkeepers that this type of article must not be kept in stock for long periods.

The tinned raspberries were labelled " In Heavy Syrup " and the Analyst certified the original strength of the syrup to be deficient in sugar. The manufacturers analysed a third portion of the official sample and two unopened tins. They disagreed with the Analyst's opinion and stated that they were unable to arrive at any general conclusion regarding the strength of the original syrup. The Analyst also gave an opinion that there were difficulties in obtaining true samples of fruit in heavy syrup. In view of these difficulties and the results obtained by the manufacturers, it was considered that there would not be any advantage in proceeding further with the matter.

The sausages were satisfactory as regards general quality, but the vendor was cautioned for failing to display a notice in the shop that the sausages contained preservative.

The mixture for making iced lollies was not labelled with a list of ingredients as required by the Labelling of Food Order. The manufacturers were under the impression that the mixture could be classed as a soft drink in which case it would be exempt from the labelling provisions. However, they agreed to have the labels amended.

Complaints — Unsatisfactory Foodstuffs

A bottle of school milk containing a piece of broken glass resulted in the firm of dairymen who bottled the milk being prosecuted. They were fined £30 plus £3 3s. costs.

A firm of sweet manufacturers was prosecuted as a result of a piece of metal being found in a toffee sweet. This case resulted in a fine of £20 plus £3 3s. costs.

A packet of sliced beans was found to contain a metal bolt and the firm of frozen food manufacturers concerned was fined £20 plus £10 10s. costs.

Insecticides

During the year the Public Analyst referred to a food problem worthy of investigation, that concerning the practice of spraying crops and vegetables with insecticides. The official view is that if the spraying is properly applied and controlled there is no serious risk to the consumer. However, some concern was expressed in Parliament and in the Press that chemical residues may sometimes be present in food sold to the public. Apparently there is very little risk of contamination of root vegetables such as potatoes and turnips, but applies more to soft fruits, tomatoes, cabbages, etc. It was felt that the matter was sufficiently important to warrant sending some samples to the Analyst for the purpose of detecting spray residues and consequently samples of plums, cherries, grapes, peaches, tomatoes, cauliflowers and cucumbers were submitted. The results were very satisfactory, no trace of insecticides being found on any of the articles.

Iced Lollipops

Another scheme in which this Authority was requested to cooperate concerned the possible erosion of children's teeth by excess acidity in iced lollipops. This matter had been raised at a meeting of the Local Authorities' Joint Advisory Committee on Food Standards when it was considered that Codes of Practice for this particular produce would not be appropriate at that time, but the Association of Public Analysts underook to provide some information to the Committee on the pH value (a measure of the effective acidity) of iced lollies. A few samples of iced lollies of local manufacture were submitted to the Public Analyst for routine examination under the Food and Drugs Act and during the course of which the pH value of the samples was also determined. The Public Analyst supplied information on the samples submitted by 19 Authorities. 88 samples had an average pH value of 3.0 and the range of pH value was from 2.2 to 5.95. Only one sample reached 5.95, whilst 42 samples had a pH value as low as 2.2. In the pH scale of measurement of acidity and alkalinity, neutrality occurs at pH 7.0; any value in excess of pH 7.0 is alkaline and any value lower than pH 7.0 is acid. When all the information had been passed to the Committee it would be necessary for medical and dental opinion to decide whether iced lollies, with no standard in operation, are so acid as to constitute a serious menace to children.

Milk (Special Designation) Regulations

The above Regulations continue to be administered to ensure that all milk sold by retail is in bottles or cartons and that the correct designations are being applied. Particular attention has been given to milk classed as "Farm Bottled" as this description can only be used provided the milk is bottled by the producer on the farm premises. In a number of instances farmers have been granted Consents which exempt them from the provisions of the Regulations, but these Consents are granted by the Ministry only in instances where there is no other available supply of bottled milk.

WATER AND SEWERAGE

Water Schemes

By the end of 1961, the whole of the county had been covered by the regrouping proposals and the water undertakings of a number of district councils had been transferred to the newly formed Water Boards, leaving the undertakings of the Alston, Penrith and Wigton Rural District Councils and the Penrith Urban Council to be transferred during 1962. For this reason there was very little activity regarding new schemes during 1961, most of the district councils leaving over the submission of future schemes to the Water Boards and only completing schemes in hand.

The only new scheme was submitted by the Penrith R.D.C. for improving supplies generally in the centre and west of the rural district. This scheme proposed to carry out the improvement in three stages at an estimated cost of £96,750 and possibly Stage 1 will be completed before the transfer.

During the year, notification has been received of Ministry grants for four schemes and the County Council made similar grants in all cases.

Regrouping of Water Supplies

West Cumberland Water Board

As reported last year, the West Cumberland Water Board was constituted on 1st November, 1960, and the undertakings of the Cockermouth Rural District Council, the Maryport and Cockermouth Urban District Councils and the Workington Borough Council were transferred to the West Cumberland Water Board on the 1st April, 1962.

South Cumberland Water Board

The order for the formation of the South Cumberland Water Board was made during the year and the undertakings of the Ennerdale and Millom Rural District Councils and the Whitehaven Borough Council were transferred to the South Cumberland Water Board on 1st October, 1961.

East Cumberland and North Westmorland

Meetings of the Local Authorities in East Cumberland and North Westmorland were held during the year to discuss the regrouping of their water undertakings. The Cumberland and North Westmorland authorities were in favour of one board to cover their areas plus the South Westmorland area, but authorities in South Westmorland would not agree to this and proceeded to ask the Minister to agree to the formation of a joint board for South Westmorland only.

In view of this decision the authorities in East Cumberland and North Westmorland had no alternative but to draft an order for the constitution of a joint board to be known as the Eden Water Board to include Appleby Borough, Penrith Urban, Alston Rural, Penrith Rural, North Western Rural areas.

The draft order for the formation of the Eden Water Board has recently been published and the proposed date for the constitution of the board is 1st June, 1962, and the date of transfer of undertakings 1st April, 1963.

At the end of the year this only left the undertakings of the Wigton Rural District Council and the Keswick U.D.C. to be dealt with and early in 1962 it was learned that the Wigton Water Undertaking would be going over to the West Cumberland Water Board.

Contributions by County Councils

The Rural Water Supplies and Sewerage Acts, 1961, which came into operation in June, 1961, amended the 1944 Act and enables County Councils to contribute towards the cost of rural water schemes carried out by County Borough Councils or Joint Boards.

Sewerage Schemes

Only two new sewerage schemes were submitted this year, as against six in the previous year. These were the Millom Rural District Council's scheme for Drigg and Holmrook at a cost in the region of £26,700 and the Ennerdale Rural District Council's scheme for the sewerage of their northern parishes at a cost of £104,000. Both these schemes were prepared by the County Engineer under the County Council's scheme of affording technical assistance to district councils.

Two Ministry grants were notified during the year and the County Council made similar grants.

Grants

During the year information was received from the Minister of Housing and Local Government that the interim scheme of grants under the Rural Water Supplies and Sewerage Acts was being replaced by a more permanent method of assessment. The Ministry had evolved a formula on the basis of the Government contributing towards the high cost of rural water and sewerage schemes when compared with the cost of such schemes in urban areas, the difference being attributable solely to the longer lengths of main required to serve rural areas.

The new proposals enable the Authorities concerned to estimate the amount of Ministry grant towards the cost of schemes submitted for approval.

Water Schemes

Scheme Submitted by	Name of Scheme	General Outline	Estimated or Final Cost	Grants		Stage at 31st March, 1962
				Ministry	County	
Cockermouth R.D.C.	Buttermere Water Scheme	To supply village of Buttermere	£6150	£1400 lump sum	£1400 lump sum	Complete
Wigton R.D.C.	Water Development Scheme Stage III	To supply North-Western Parishes		£760—half year for 30 years	£760—half year for 30 years	Grant increased from £550
Ennerdale R.D.C.	Southern Area Water Supply Stage V, Phase I	To supply water to Gosforth via a 6 in. main from Winscales reservoir	£31000	£456—half year for 30 years	£456—half year for 30 years	In progress
Millom R.D.C.	Water Supply to Northern Parishes	To supply Northern Parishes	£161000	£1427—half year for 30 years	£1427—half year for 30 years	In progress
Wigton R.D.C.	Water Development Scheme Stage IV. Pt. I	Trunk main Fletchertown to Balladoyle	£148624	—	—	Work proceeding
Wigton R.D.C.	Water Development Scheme Stage IV, Pt. II	Supply to Caldbeck and district	Revised cost £107925	—	—	Approved in principle by Ministry

Scheme Submitted by	Name of Scheme	General Outline	Estimated or Final Cost	Grants		Stage at 31st March, 1962
				Ministry	County	
Penrith R.D.C.	Water Supplies Central and Western areas	To improve supplies in the rural district		—	—	
		Stage I—New 6 in. main to Armathwaite	£2300	—	—	Scheme approved as sound and capable of meeting long standing need.
		Stage II—New reservoir at High Larches and duplication of main	£39456	—	—	
		Stage III—Improvements in distribution of Dowthwaite Head supply	£33894	—	—	Contract let for Stage I

Millom R.D.C.	Drigg and Holmrook Sewerage	Sewerage works at Drigg to which the sewage from Holmrook would be pumped. Scheme prepared by County Engineer for District Council	£260700	—	—	Approved as sound and adequate
Ennerdale R.D.C.	Egremont and Braystones outfall sewer	Storm relief and sewerage	£77590	Half-yearly payments of £255 for 30 years	Half-yearly payments of £255 for 30 years	Work proceeding
Border R.D.C.	Rockcliffe sewage disposal works	Sewage disposal works and sewerage of the village of Rockcliffe		Half-yearly payments of £148 for 30 years	Half-yearly payments of £148 for 30 years	Work proceeding
Ennerdale R.D.C.	Northern Parishes Sewerage Scheme	Scheme for Distington, Lowca, Moresby and Parton. Revised scheme providing treatment works at Parton instead of the proposed sea outfall. Scheme prepared by County Engineer	£104000	—	—	Approved as sound and adequate
Penrith R.D.C.	Kirkoswald and Lazonby Sewerage	Combined treatment works at Kirkoswald to which sewage from Lazonby would be pumped	£44100	—	—	Work proceeding
Keswick U.D.C.	Sewerage disposal works	Modification and additions to sewerage works prepared by County Engineer on behalf of District Council	£56000	—	—	Scheme approved in principle by Ministry

Housing

The following table on Housing Statistics for the County for 1961 shows that some progress has been made during the year, particularly in the provision of new houses for the elderly. During 1960, 66 houses were completed for the aged whilst for 1961 the figure increased to 107.

Applications for Grants for Improvement numbered 694 during the year compared with 560 the previous year and the number of grants approved were 653 and 551 respectively.

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For year ended 31st December, 1961

(N.B.—Corresponding figures for 1960 are shown in brackets)

	Alston R.D.C.	Border R.D.C.	Cockermouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	Whitehaven Borough	Workington Borough	Cockermouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.
Population — 1951	2327	29845	20455	29676	13428	11723	23746	24620	28891	5235	4868	12234	10492
(Census) — 1961	2198	29647	20886	30870	15087	11606	21868	27541	29507	5823	4752	12334	10931
A 1 Total number of occupied dwelling houses in the district	855 (865)	8425 (8276)	6473 (6345)	9406 (9260)	4573 (4495)	3668 (3651)	7100 (7168)	7745 (7745)	8870 (8860)	2069 (2030)	1670 (1667)	3999 (4010)	3439 (3385)
2 Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings	13 (—)	6 (10)	6 (11)	146 (154)	27 (27)	15 (25)	22 (20)	141 (75)	68 (55)	87 (31)	7 (4)	88 (85)	12 (5)
3 Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost	44 (60)	241 (420)	28 (32)	557 (660)	66 (43)	114 (123)	222 (256)	200 (200)	60 (50)	190 (246)	7 (7)	140 (161)	92 (101)
4 Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit	80 (90)	720 (760)	N.A. (N.A.)	1650 (1780)	318 (108)	480 (500)	1283 (1303)	N.A. (150)	50 (70)	28 (28)	95 (95)	103 (113)	56 (48)
5 Number of houses found to be overcrowded	7 (6)	14 (27)	2 (3)	6 (6)	7 (13)	45 (52)	6 (4)	4 (—)	— (—)	— (—)	— (—)	— (—)	2 (1)
B WAITING LISTS Total number of valid applicants on Council's waiting list exclusive of those living in houses under A 2 and 3 above	22 (14)	245 (210)	490 (437)	505 (427)	211 (212)	No list kept	402 (334)	880 (880)	909 (915)	56 (97)	No list kept	316 (332)	254 (258
C NEW HOUSES COMPLETED DURING THE YEAR													
1 By or for the Council													
For aged persons	— (—)	8 (18)	9 (15)	30 (12)	24 (—)	4 (—)	6 (—)	12 (12)	8 (—)	6 (—)	— (—)	— (—)	— (9)
For agricultural workers	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	6 (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
Flats	— (—)	— (14)	— (—)	— (—)	— (—)	— (—)	— (—)	14 (14)	— (—)	— (—)	20 (—)	— (—)	— (—)
General Purpose Houses	— (—)	51 (10)	59 (6)	62 (120)	— (—)	4 (5)	46 (30)	39 (39)	50 (14)	— (5)	— (—)	25 (72)	22 (—)
2 Private building	— (2)	136 (206)	113 (102)	180 (62)	54 (30)	28 (17)	45 (22)	80 (80)	72 (50)	35 (28)	2 (7)	1 (1)	32 (54)
Total	— (2)	195 (248)	181 (123)	272 (194)	78 (30)	36 (22)	103 (52)	145 (145)	130 (64)	41 (33)	22 (7)	26 (73)	54 (63)
D 1 Number of houses for which application was made by private persons for Improvement Grants	7 (8)	106 (101)	76 (63)	73 (59)	86 (84)	57 (53)	106 (67)	17 (17)	79 (47)	8 (13)	6 (11)	32 (21)	21 (16)
2 Number of houses for which grants were approved	7 (8)	105 (99)	74 (62)	67 (55)	84 (81)	54 (49)	104 (68)	16 (17)	77 (55)	8 (12)	6 (11)	32 (21)	19 (13)
3 Number of houses where improvements were carried out and grants paid	8 (9)	79 (49)	51 (75)	43 (27)	69 (66)	40 (46)	47 (141)	15 (15)	63 (42)	2 (7)	0 (6)	28 (13)	16 (12)
4 Number of houses purchased or taken over by the Council with a view to improvement or conversion	— (—)	1 (4)	— (—)	— (—)	— (2)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
5 Number of houses improved by the Council (i) with grant	— (—)	— (—)	— (—)	3 (—)	— (—)	— (—)	— (23)	— (—)	— (—)	— (—)	5 (—)	— (—)	— (—)
(ii) without grant	— (—)	— (6)	— (—)	— (—)	— (1)	— (—)	— (2)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
F TEMPORARY ACCOMMODATION Number of families occupying camps and temporary buildings	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	10 (23)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
F HOUSING PROGRAMME Estimated number of houses to be built during the ensuing year (i) Private	— (—)	N.A. (N.A.)	100 (200)	160 (120)	75 (56)	20 (20)	30 (27)	80 (80)	60 (50)	32 (50)	6 (6)	25 (—)	57 (40)
(ii) Council	14 (18)	40 (60/70)	25 (50)	200 (666)	44 (68)	20 (20)	80 (62)	174 (174)	120 (340)	56 (42)	18 (14)	90 (50)	10 (36)

CARAVAN DEVELOPMENT

Mr. Kenneth Steen, County Planning Officer, has kindly furnished me with the following note on the problem of Caravan Development in the County.

At the present time about 750 persons live in 300 residential caravans in the County. There are, however, some 1,700 pitches occupied through the summer season for holiday purposes. The administrative procedure for dealing with caravan development is now well integrated from the planning and public health points of view following the coming into operation of the Caravan Sites and Control of Development Act, 1960. The requirements of all authorities concerned are being met more and more by the site operators following negotiations on applications for planning permission and site licences required under the Act of 1960.

There are two main reasons why people live in caravans. Firstly, to provide temporary housing accommodation in the absence of sufficient permanent homes, and, secondly, to provide holiday accommodation whether it be for touring or a static holiday home. The former raise difficult problems particularly from the public health point of view, as, unfortunately, the standards recommended for residential caravans are much lower than those under the Housing Acts for permanent housing accommodation. For example, very few caravans are capable of taking more than two persons according to the accepted overcrowding standards under the Housing Acts, yet the average occupancy of residential caravans is approximately 2.5 persons/caravan.

In addition to the restriction of a residential caravan from the overcrowding point of view there is also a need for hardstandings, space around the caravans, water supply, drainage and refuse disposal arrangements and in addition a drying space for clothes. Residential caravan sites, therefore, need almost the same facilities and amenities as a permanent housing estate if they are to be occupied for some time. In addition they should be reasonably near to shops, schools and places of work and be away from industrial or highway dangers. It is considered that the residential caravan will continue to be a problem for the housing authorities for some time to come.

Holiday caravans are generally used for the summer season only, but there is a tendency for these to be occupied throughout the winter months despite the fact that the standards for holiday caravans are lower than for residential caravans.

APPENDICES

I. Annual Report on Tuberculosis and Other Chest Diseases in East Cumberland.

II. Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland.

III. Mass Radiography.

IV. County Council Clinics.

APPENDIX I

Annual Report on Tuberculosis and other Chest Diseases in East Cumberland in 1961

Introduction

The volume of work at the chest centre remained at a high level during 1961.

In the East Cumberland Hospital Management Committee area notifications of pulmonary tuberculosis showed a decrease of 14 over the whole area. Whilst this decrease is particularly noticeable in the Carlisle City and North Westmorland areas, the apparent increase in the East Cumberland county area should not give cause for alarm, for as noted in Table 2 the number of new cases of pulmonary tuberculosis discovered during the previous year, for the East Cumberland county area was an exceptionally low figure —so exceptional that one almost anticipated that more cases would be discovered in this area during 1961.

The total number of notified cases of tuberculosis, which includes East Cumberland, under supervision at the chest centre had dropped from 1,450 in early 1960 to 1,413 on the 1st January, 1961. This high figure is undoubtedly an indication of the intensive diagnostic measures carried out during the 1950-60 decade, and is also an index of the success of our therapeutic measures. Large numbers of these patients are now being removed from the Registers as completely cured and no longer requiring chest centre supervision. During 1961 no less than 140 patients names were so removed. The number of cases under supervision at the chest centre will undoubtedly be reduced, and at 31.12.61 the total number had been further reduced to 1288. This decline in the total number will continue, and is most satisfactory. Almost three times as many patients had their names removed from the Register as cured as were detected as new cases during the year.

For the first time the number of new cases of lung cancer during 1961 has exceeded the number of new cases of tuberculosis. Unfortunately, the majority of these cases are beyond the scope of our present regimen of therapy.

The mass radiography units allotted to the Special Area continue to play a vital role in diagnosis. The static unit in Carlisle is particularly valuable, and the high pick-up rate of this unit in both tuberculosis and neoplasm should be noted. Encouraged by these results, we are proposing to employ the mobile unit as a

static unit in Whitehaven every Friday in the near future and it is hoped that the general practitioners in this area will find this diagnostic service as valuable as it is here in Carlisle. As most of the cases passing through the static unit are cases under their own general practitioners and are referred by them, the work of such a unit prevents overloading the work at the chest centre.

Tuberculosis

Table 1 shows the number of notifications throughout England and Wales for 1961 and the preceding five years:—

Table 1

Year	Pulmonary	Non-pulmonary
1956 ...	31642	4173
1957 ...	29310	3807
1958 ...	26595	3503
1959 ...	21063	3855
1960 ...	21129	2861
1961 ...	19187	2728

Table 2 shows the number of notifications for the same period in East Cumberland:—

Table 2

Year	Pulmonary	Non-pulmonary
1956 ...	54	10
1957 ...	54	12
1958 ...	47	15
1959 ...	50	11
1960 ...	19	6
1961 ...	25	8

Table 3 shows the age and sex distribution of the new cases discovered in East Cumberland during 1961.

Table 3

	Under 5	5-15	15-25	25-35	35-45	45-55	55-65	65+	Total
RESPIRATORY									
Males	—	1	—	4	4	1	3	2	14
Females	1	1	3	1	3	3	—	1	11
NON-RESPIRATORY									
Males	—	—	—	1	1	—	—	2	4
Females	—	—	—	1	1	1	1	—	4

Once again, almost half the new cases in males in the whole area were over 45 and I would again stress the importance of X-ray examination for males of this age group no matter how trivial their symptoms may be.

Eleven East Cumberland names were removed from the Tuberculosis Registers during the year, but none died specifically from pulmonary tuberculosis itself.

Although death from pulmonary tuberculosis is now rare, and there is strong evidence to suggest that the tuberculosis morbidity in the community has markedly declined, tuberculosis is still prevalent. A negative chest X-ray, although ruling out a pulmonary lesion, does not necessarily exclude abdominal tuberculosis. A Mantoux test is usually positive in the presence of tuberculous disease, but even a Mantoux test can remain negative in the presence of a miliary or abdominal infection.

Table 4 gives the number of pulmonary and non-pulmonary cases in East Cumberland on the chest centre register at the end of 1961.

Table 4
Clinic Register as at the end of 1961 — East Cumberland

	RESPIRATORY			NON-RESPIRATORY			TOTALS			GRAND TOTAL	
	M	W	Ch	M	W	Ch	M	W	Ch		
A (1) No. of notified cases of TB on Register 1.1.1961 ...	273	237	15	17	55	11	290	292	26	608	(625)
(2) Transfers in from other areas during the year ...	6	3	—	—	2	—	6	5	—	11	(23)
(3) Cases lost sight of which returned during year ...	—	—	—	—	—	—	—	—	—	—	(3)
B No. of NEW cases diagnosed as TB during the year TB minus ...	7	6	3	1	2	—	8	8	3	19	(18)
TB Plus ...	7	5	—	3	2	—	10	7	—	17	(7)
Totals of A and B ...	293	251	18	21	61	11	314	312	29	655	(676)
C No. of cases in A and B written off Register during year—											
(1) Recovered ...	19	28	1	5	3	3	24	31	4	59	(28)
(2) Died (all causes) ...	8	2	—	1	—	—	9	2	—	11	(12)
(3) Removed to other areas ...	4	11	—	—	4	1	4	15	1	20	(25)
(4) Other reasons	1	—	—	—	1	—	1	1	—	2	(3)
Totals of C ...	32	41	1	6	8	4	38	49	5	92	(68)
D No. of notified cases of TB on Clinic Register on 31.12.61 ...	261	210	17	16	53	6	277	263	23	563	(608)

The figures in parenthesis are the corresponding figures for 1960

Table 5 relates to pulmonary tuberculosis only and gives respectively the number of new cases, quiescent cases, and the number of resistant cases in East Cumberland on the registers at the chest centre at the end of 1961.

No new cases of drug resistance were discovered in 1961. In general the problem of resistance reflects the standard of our therapeutic measures. As far as primary resistance is concerned in untreated patients, no patient during 1961 was found to be resistant to even one of the anti-tuberculous drugs.

Table 5

	In Hospital			AT HOME									Total
				Still positive			Formerly pos. neg. at end of 1961			Negative			
	M	F	Ch	M	F	Ch	M	F	Ch	M	F	Ch	
No. of active cases ...	10	4	3	3	1	—	10	4	—	9	9	—	53
No. of quiescent cases ..	—	—	—	—	—	—	—	—	—	245	245	20	510
No. of resistant cases ...	—	—	—	1	—	—	—	—	—	—	—	—	1

Chemotherapy in pulmonary tuberculosis gives excellent results, providing that the correct drug combinations are used and that the patients take these drugs as prescribed. All patients who initially have a positive discharge should be treated in hospital until conversion has been obtained.

The administration of steroids with anti-tuberculous drugs can be valuable in certain cases, but such combined therapy requires considerable deliberation before being embarked on; there should, for example, be no evidence to suggest that the tubercle bacilli concerned are not still sensitive to the anti-tuberculous drugs used, otherwise steroid therapy might cause spread of the tuberculous disease.

There has been no alteration in our regimen of treatment since the last report for 1960. Chemotherapy intensively applied has so reduced mortality and incidence rates that eradication of the disease can now be regarded as feasible. Certain problems, however, remain, the biggest is probably the incidence of not only tuberculosis but chest diseases as a whole in elderly men over the age of 45.

In the area covered by the chest centre we have not previously had the problem of immigrants increasing the incidence of the disease in the area. During the past year, however, no less than six immigrants have been found to be suffering from pulmonary tuberculosis—two Chinese, two Portugese, one Pakistani, and one Italian. To make matters worse five of these immigrants worked in hotels or catering establishments. None had had an X-ray prior to entering this country. It seems all wrong to me that whereas anyone from the Special Area desiring to emmigrate to U.S.A. or Canada must have a clear X-ray prior to embarkation, immigrants should be allowed into Great Britain without any such safeguard. All of these patients have required intensive hospital and chemotherapy treatment. The risk to the general public in allowing anyone into this country without a clear X-ray check is a big one.

In all six cases the usual intensive contact examinations were required entailing considerable chest physician time, etc. Matters were made worse by the fact that one of the immigrants took up duty at a factory a few days after we had carried out our annual mass radiography survey of this factory. His diagnosis some weeks later, when he fell ill, necessitated a second similar survey

being carried out, involving considerable effort and expenditure, not only to the chest service but to the factory concerned.

Further, to have six immigrants in a total new case incidence of 58 for the year is too big a percentage.

All immigrants into this country should obviously have adequate X-ray examination before entry so that our efforts in eradicating the disease here should not be halted, and the intended legislation to this effect is to be welcomed.

Contact work has been continued as in previous years, and Table 6 shows the number of new East Cumberland contact examinations at the chest centre and the number of these contacts who have been notified as suffering from active tuberculous disease for the past five years.

Table 6

	No. of NEW contacts seen	No. of contacts diagnosed as tubercle
1956 ...	920	4
1957 ...	1126	5
1958 ...	986	3
1959 ...	1152	6
1960 ...	906	—
1961 ...	898	4

Table 7 shows the number of contacts and hospital staff who have been vaccinated with B.C.G. vaccine over the same period. Most of the adult contact examinations over the age of 15 continue to be carried out in the mass radiography unit, thus relieving pressure at the chest centre.

Table 7

	Contacts		Hospital Staff	
	M	F	M	F
1956 ...	38	46	—	27
1957 ...	74	69	—	34
1958 ...	79	76	3	45
1959 ...	77	79	1	49
1960 ...	43	57	14	25
1961 ...	59	76	6	37

The number of beds in the area available for the treatment of chest cases are:—

Ward 18, Cumberland Infirmary, Carlisle ...	14
Longtown Chest Unit	26
Blencathra Hospital	25

Rehabilitation panels continue to be held monthly in respect of all patients who attend at the chest centre.

Cancer of the Lung

Table 8 shows the number of new East Cumberland cases of lung cancer seen at the chest centre during the past seven years:—

Table 8

Year	No. of new cases
1955	12
1956	11
1957	11
1958	27
1959	31
1960	20
1961	30

Of the total number of 64 new cases seen for the whole area served by the centre in 1961 only nine were females. Unfortunately, comparatively few patients were found after investigation to be fit for radical surgery. Until new and more effective therapy is available we must continue to concentrate on securing earlier diagnosis in these cases.

Just as in tuberculosis, there is no syptom characteristic of early lung cancer. A man may have had bronchitis for several winters but when his cough suddenly become more severe and his sputum more purulent and probably tinged with blood, then obviously some factor other than bronchitis is present. Likewise, chest pain of unexplained origin and a change in the cough habit itself persisting for more than two or three weeks in persons over 45 should create suspicion. Haemoptysis is a symptom common to many chest disease; bronchiectasis is more liable to cause profuse bleeding than probably any other chest condition. Stained sputum, however, particularly in men over 45, is likelier to be due to lung cancer than to anything else.

In most cases there are no distinctive physical signs, and indeed, in a recent survey elsewhere, over 50 per cent. of the cases of lung cancer had no definite physical signs at all. Routine X-ray examination will give a diagnosis in most cases, but, in some, added measures such as tomography and bronchography will be necessary to secure a diagnosis.

The origin of lung cancer remains obscure despite wide and extensive research. More adequate knowledge of the pathology and physiology of cancer is required before prevention can be achieved. Certain agents are freely associated with an increased incidence of the disease such as radioactive material, nickel, and asbestos: less generally accepted agents are tobacco smoke and certain petroleum derivatives. There is much circumstantial evidence associated with the latter in the evidence of lung cancer. Most of the cases of lung cancer coming to our notice at the centre are heavy cigarette smokers, but there is a small percentage who are non-smokers.

Periodic X-ray examination, therefore, is still the only possible way of obtaining early detection of lung cancer, but even with this there is no guarantee that all of the so-called early cases will be found amenable to surgery. Indeed, as pointed out in previous reports, therapy in cancer is still most inadequate. All one can say at present is that any patient, particularly men over 45, who present with such symptoms as cough, stained sputum, and chest pain hould be investigated, and that all men of this age group should have a yearly X-ray examination.

Sarcoidosis

There are now 43 cases of pulmonary sarcoidosis in all under supervision at the chest centre. This is more often a disease of the young adult rather than one of the younger or older age groups. Many cases are first discovered on routine mass radiography examination, and many do not require any therapy. Indeed, the prognosis in most cases so discovered is excellent. Only very few cases, those with extensive lung parenchymatous changes, or with a considerable degree of mediastinal glandular enlargement, or both, require therapy. Only a small proportion of these cases require in-patient treatment in hospital, and the results of therapy are in general excellent.

Bronchiectasis

Table 9 shows the number of cases of bronchiectasis on the register in East Cumberland and attending for physiotherapy and medical supervision. The number of new cases coming to our notice still remains at a high level. Most of the new cases, however, are in the older age groups and there are fewer cases in younger people. This is satisfactory in that the presence of bronchiectasis in the younger persons would naturally infer that adequate antibiotic therapy had not been given in previous infections.

Table 9

No. of cases of bronchiectasis on Register at 1.1.62.	139
New cases diagnosed in :—	
1956	19
1957	18
1958	19
1959	16
1960	16
1961	17

Bronchitis, Asthma and Emphysema

Chronic bronchitis continues to be the chief cause of morbidity and unemployment in this area. Full use continues to be made of the physiotherapist, and as the numbers of these cases are considrable much work is entailed in their supervision and the control of treatment.

Every effort is made to treat bronchospasm of whatever cause. Respiratory irritants such as tobacco smoke should be avoided in cases of bronchitis, even though such restrictions are unwelcome to the patients.

Chronic cough, whatever the cause, is to be controlled although the sevcre asthmatic attack probably does most damage in producing early emphysematous changes, milder bronchospasm with which the patients learn to live in relative comfort can also produce trauma. This is where physiotherapy is of value. The exercises are generally individualised and each exercise mastered before a new one is added. All respiratory distress is avoided during physiotherapy, and naturally progress in many cases is relatively slow. Many cases do present with considerable

emphysema and the treatment of these cases is largely medical. The recent decline in the need for surgery in tuberculosis, however, has enabled the thoracic surgeons to pay more attention to the treatment of localised emphysematous bullae. The small number of cases done in this area already has resulted in unexpectedly gratifying results.

It is very difficult in a disease such as emphysema, with the patient already breathless, to decide to refer a case to the thoracic surgeon. Until now, the decision to refer has been based on the radiological appearances plus simple vital capacity measurements. In future, however, greater emphasis will obviously be placed on the investigation of such patients in a regional physiological laboratory. Ultimately, one hopes that with increased knowledge becoming available as the results of such tests, simpler apparatus will be available for use in out-patient departments so that more rational therapy an be instituted and supervised.

APPENDIX II

Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland in 1961

In the annual report for this area in 1960 attention was drawn to the halt in what had been a progressive decline in both the attack rate and the killing rate of tuberculous disease over a period of years. During 1961, both these aspects of local epidemiology showed a further welcome improvement and from the ensuing details of the work of the Chest Service for 1961, tuberculosis can be seen as a disease over which a very fair measure of control appears now to be exercised. Fewer people than ever before are now found suffering from it: more patients are being cured: treatment is more rapid and certain; and its impact on the social and economic life of the community is now so slight as to constitute only barely a public health issue. Further, the danger of relapse, which in earlier years provoked in the patient's mind justifiable insecurity, and in the chest physician's practice the need for frequent reassessment of patients, has receded into an insignificance that is both reassuring and definite.

New Cases of Tuberculosis

New cases of all forms of tuberculosis in West Cumberland numbered 69: of these, 46 were males and 23 females. The age groups contributing the major portion of new cases were 20—35 years inclusive (20 cases) and 50—65 years (21 cases). Below the age of 20, there were 8 new cases, approximately half the number for the same group in 1960 and one quarter of the number of similar cases in 1958. The total number of new cases yearly has been more than halved since 1957, as can be seen from the following table.

Table I

Year	Total Number of Notified Cases
1957	151
1958	125
1959	97
1960	111
1961	69

Childhood Tuberculosis

Childhood tuberculosis still occurs: this year, however, the number of cases notified below age 14 was half that of 1960 — 3 (6). The case rate for this area at 0.5 per 1,000 population is the lowest recorded since the inception of the National Health Service.

Tuberculosis Register

The Tuberculosis Register at the 31st December, 1961, contained 874 cases of respiratory disease and 116 of non-respiratory forms totalling 990 cases for all forms of disease. This compares favourably with 1960 (1138 cases) and 1959 (1529 cases). Some 249 cases were removed from the register recovered, whilst less than a tenth of this figure — 22 — were removed because of demise. Of the 22 deaths, 7 were attributable to tuberculosis. Of some 890 cases on the Register on the 1st January, 1961, 93 per cent. were assessed quiescent during the year, showing a slight improvement over the 91 per cent. for this group a year earlier. The proportion of new cases entered on the register in 1961 with non-quiescent disease was higher at 92 per cent. than year ago — 81 per cent.

The number of cases frankly infectious at diagnosis is not so high as a year ago, but at 37 per cent. of all new cases is much higher than need be the case were all available diagnostic facilities adequately employed in the area. Throughout the United Kingdom in 1960 some 50 per cent. of new cases were found infectious at the time of diagnosis: obviously much avoidable infection occurs still. The sources of referral of cases gives a clear indication where the main diagnostic power now lies. From the 100 cases found on the M.M.R. Unit in 1955, this diagnostic weapon's yield has fallen to 14 in 1961: symptomatic illness of patients seen in general practitioners' surgeries provided 21 cases, whilst patients in any of the group hospitals provided 16 new cases. Routine X-ray of employed personnel in one large employing authority yielded 3 new cases. From this it can be seen that the general practitioner/hospital contribution of 37 cases is more than half the new notifications for the year, whilst in only 17 cases was diagnosis made by use of routine radiography.

Mortality Rate

Mortality from tuberculosis was, as has been stated, lower than in previous years. Whilst it is probable the Registrar-General's returns will show some deaths partially attributable to

or associated with tuberculosis in excess of the 7 deaths mentioned, in only this number was death directly attributable to the disease. The mortality rate on this basis a 0.05/1,000 is the lowest recorded in West Cumberland.

Treatment

Treatment of tuberculous and non-tuberculous chest conditions has continued at Ward E, The West Cumberland Hospital, Hensingham. No beds have been unavailable for any reason during the year. Of the 41 beds available, the average daily bed occupation has been 30.93: discharges and deaths totalled 154 (123 in 1960) and the average duration of stay was 73 days (83 days in 1960). Surgical treatment has again been carried out at Seaham Hall, 16 patients requiring this form of control (19 in 1960; 31 in 1959).

Efforts designed to limit the number of patients harbouring drug-resistant organisms have effected some improvement on the 1960 figures. The separate register of such cases for the year showed 25 cases with partly or completely resistant organisms in their sputum (32 for 1960): of these, 9 were resistant to all three standard "first-line" drugs, and 14 resistant to one or two of the three.

Summary of Chest Clinic Statistics

Table II

Clinic	No. of Sessions		New Patients		Total Attendances	
Workington ...	176	(173)	826	(869)	2966	(3038)
Egremont ...	152	(152)	670	(862)	2720	(2973)
Millom ...	11	(13)	48	(61)	209	(204)
Total ...	339	(338)	1544	(1792)	5895	(6215)

Figures in parenthesis refer to 1960

This table sets out the extent of reduced volume of work at the several clinics. Whilst the total number of tuberculous cases and contacts both new and old has fallen very considerably in the past few years, non-tuberculous conditions are increasing in both out-patient and in-patient work. The proportions are not reflected in this table. However, the number of non-tuberculous patients seen at Chest Clinics in 1961 was 1943: which may be compared with the total tuberculous of 1755: and contacts totalling 1,565. At consultative sessions the proportion of tuberculous to non-tuberculous conditions seen is now less than 1.1.

Familial Contacts

Familial contacts of tuberculous cases, both notified and unnotified, have again been seen at the Clinics or offered routine radiography at the M.M.R. Unit. New contacts seen for the first time totalled 934 (949 in 1960) and of these 5 were found initially or subsequently to have developed disease. Contacts under 15 years of age were remarkably free of both disease and evidence of infection. In the 0—4 years age group, no child was found to react to 1/1000 old tuberculin, out of 283 infants seen. In the 5—9 years age group, 3 per cent. were found infected in 233 seen: and in the 10—14 years group, 6.3 per cent. reacted. Vaccination with B.C.G. was extended to 587 contacts (598 in 1960).

Table III

Age	No. Tested 1961	Reactor Rate % 1961	1960	1959
0— 4	283	—	1.4	4.4
5— 9	233	3.0	2.7	4.7
10—14	89	6.3	15.6	15.7

From Table III, which sets out the observed reactor rate of new contacts to 1/1000 O.T. in the years 1961, 1960 and 1959, the favourable trend towards freedom from infection can be seen in each successive year in the youngest (infantile) age group. Children aged 5—9 show little improvement over the period 1960-61, but an appreciable improvement since 1959: the most marked change however is in the 10—14 years group which, as has been noted in previous reports, up to 1960 had shown no very significant decline below 15—17 per cent. This year for the first time this age group is showing a drop in reactor rate which may well be reflected in the comparative freedom from notified disease in the 15—20 years age groups in the next five years. It appears probable that measures of control and prevention established in this community 10 years ago are now beginning to bear fruit in the young adult population.

Case Finding Procedures

Case Finding procedures have continued along well established lines of previous years. The Mass X-Ray Unit statistics relating to West Cumberland are set out below.

Table IV

Source of Examination	Mini. films	Large films	Clinical exams.	Active T.B.	Inactive T.B.	Br'sis.	Neo-plasams	Pn'sis.	Cardiac Con-ditions
Doctors' Cases	49	17	2	1	1	1	—	—	—
Contact Cases	597	44	4	1	1	—	—	5	2
Scholars	724	5	2	—	—	1	—	—	—
School Staff	—	—	—	—	—	—	—	—	—
General Public	7034	298	72	5	10	5	4	34	17
Surveys	6414	156	39	6	8	3	1	3	5
M. D. Patients	—	—	—	—	—	—	—	—	—
Totals	14818	520	119	13	20	10	5	42	24

From the table the record low attendance of 14 thousand is perhaps as remarkable as any other piece of information. The case rate of approximtely 1/1000 for tuberculosis is higher than in previous years.

Routine ante-natal chest X-rays have become firmly established and a total of 1,051 expectant mothers were so examined in 1961. Of these, 816 were booked for confinement at Workington and Maryport and 235 at Whitehaven. From this group, 107 infants were vaccinated in the neonatal period with B.C.G., either because of a family history of tuberculosis or because of tuberculous stigmata on a maternal chest X-ray.

Non-Tuberculous Conditions

The main non-tuberculous conditions of significance amongst Chest Clinic patients continue to be pneumoconiosis, bronchial carcinoma, the respiratory allergies, a declining number of cases of bronchiectasis and other miscellaneous entities which constitute no public health problem. However, increasing attention is now being paid to the chronic bronchitic with emphysema and its cardiac sequelae: whilst treatment for this condition is by no means definitive, much can be done by appropriate supportive measures at times of epidemic infection. Provision for inpatient treatment has already been made and is likely to continue.

An increasing number of cases of cancer of the lung continues to be seen at Chest Clincs locally, in keeping with the trend noted throughout the country in general. The numbers seen at Chest Clinics here are, however, only a portion of those occurring in the community: the only sources of full information are the annual reports of the Medical Officers of Health for the various sanitary areas: from which it appears that something over twice the number of cases passing through the Chest Clinics are dying annually in West Cumberland. During 1961, 18 cases were diagnosed at Chest Clinics, and of these 3 did not survive the year. The total number of deaths due to lung cancer in patients attending the Chest Clinic during 1961 was 13. This disease, with chronic bronchitis, now constitutes the major public health problem in respiratory disorders.

APPENDIX III

MASS RADIOGRAPHY

Report on the Work of the Mass Radiography Unit during the year 1961

(NOTE—Figures given in brackets throughout the report relate to the corresponding figures for 1960.)

Both the Static and Mobile Units were fully operational throughout the twelve months of 1961. Early in 1962 both units were converted from 35 mm to 100 mm X-ray sets. The standard of the films as a result of the conversion has been greatly improved. Figures shown in the present report which refer to the number of persons referred for further X-ray films will be omitted in future as it is unnecessary with the 100 mm film. During 1961 both units operated satisfactorily with unqualified radiographer staff and the quality of the films produced showed no deterioration.

Groups Examined

In addition to carrying out surveys at works and factories, surveys of the general public were carried out on 60 occasions. 1,113 (1,627) contact cases were X-rayed, 516 from the East Cumberland area and 597 from West Cumberland.

Results

35,807 (38,746) persons were examined by the Units during the year.

Number recalled for full sized X-ray film	2,230	— 6.23% of total
	(2,330	— 6.01%) examined
Number referred for clinical examination	439	— 1.23% of total
	(415	— 1.07%) examined
Number failing to attend for full sized film	81	— 3.63% of those
	(96	— 4.12%) recalled

Table 1 shows the number of abnormalities revealed during 1961 throughout the whole of the Special Area.

Table 1

Abnormalities Revealed	No. of Cases Found		Percentage of Total Examined	
(1) Non-tuberculous conditions—				
(a) Bronchiecstasis ...	33	(28)	.09	(.07)
(b) Pneumoconiosis ...	46	(54)	.13	(.14)
(c) Neoplasm ...	29	(26)	.08	(.07)
(d) Cardiovascular conditions ...	168	(140)	.47	(.36)
(e) Miscellaneous requiring investigation ...	36	(37)	.10	(.10)
(2) Pulmonary Tuberculosis—				
(a) Active ...	31	(39)	.09	(.10)
(b) Inactive requiring supervision ...	31	(32)	.09	(.08)
(c) Active (Previously Known) ...	2	(—)	.006	(—)

Table 2 gives a detailed analysis of the work of the Units both Mobile and Static with the former divided as between East and West Cumberland.

Table 2

	STATIC UNIT CARLISLE					MOBILE UNIT EAST CUMBERLAND							MOBILE UNIT WEST CUMBERLAND						
Source of examination	Doctors' cases	Contact cases	Students 15 years and over	General Public	TOTALS	Doctors' cases	Contact cases	Students 15 years and over	School staff	General Public	Surveys	TOTALS	Doctors' cases	Contact cases	Students 15 years and over	School staff	General Public	Surveys	Mentally defective patients	TOTALS
Miniature Films ...	1917	45	—	713	2675	29	471	1431	171	8780	7432	18314	49	597	724	—	7034	6414	—	14818
Large Films ...	380	9	—	131	520	8	31	38	7	592	514	1190	17	44	5	—	298	156	—	520
Clinical Examinations ...	131	1	—	25	157	1	2	4	—	85	71	163	2	4	2	—	72	39	—	119
Active Tuberculosis ...	14	—	—	2	16	—	—	—	—	3	1	4	1	1	—	—	5	6	—	13
Inactive Tuberculosis requiring supervision ...	9	—	—	2	11	—	—	—	—	—	—	—	1	1	—	—	10	8	—	20
Bronchiectasis ...	9	—	—	3	12	—	—	—	—	8	3	11	1	—	1	—	5	3	—	10
Neoplasms ...	10	—	—	3	13	—	—	—	—	5	6	11	—	—	—	—	4	1	—	5
Pneumoconiosis ...	—	—	—	—	—	—	—	—	—	1	3	4	—	5	—	—	34	3	—	42
Cardiac Conditions ...	14	—	—	3	17	1	7	3	—	94	24	118	—	2	—	—	17	5	—	24

Table 3 gives the relative figures as between East and West Cumberland for the past eight years.

Table 3

Year	EAST CUMBERLAND						WEST CUMBERLAND					
	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis
1954 ...	49	438	6	217	39	1	100	381	6	101	22	133
1955 ...	51	455	10	363	38	3	60	302	1	70	25	80
1956 ...	46	338	8	360	37	3	56	258	2	53	15	61
1957 ...	37	312	7	368	18	2	24	226	4	72	24	92
1958 ...	40	153	10	321	27	2	16	81	4	90	16	125
1959 ...	33	40*	13	241	37	3	14	24*	4	39	15	71
1960 ...	21	11*	19	120	19	2	18	21*	7	23	9	52
1961 ...	20	11*	24	144	23	4	13	20*	5	24	10	42

* Requiring Supervision

Tables 4 and 5 refer solely to the area covered by the East Cumberland Hospital Management Committee. Table 4 shows the number of new cases of pulmonary tuberculosis discovered and Table 5 the number of new cases of neoplasm discovered in each case since 1954.

Table 4

Year	No. of new cases	Number with positive sputum	Percentage of new cases with positive sputum	No. of new cases referred by M.M.R.	Percentage of new cases referred by M.M.R.	Percentage positive sputum cases found by M.M.R.
1954 ...	170	56	33	36	21	13
1955 ...	139	42	30	43	31	21
1956 ...	125	39	31	39	31	18
1957 ...	125	42	34	33	26	29
1958 ...	117	32	27	29	25	9
1959 ...	116	31	27	28	24	6
1960 ...	72	28	39	21	29	18
1961 ...	58	20	34	20	34	20

Table 5

	1954	1955	1956	1957	1958	1959	1960	1961
No. of cases of neoplasm seen at Chest Centre ...	16	21	29	38	59	59	54	64
No. discovered by M.M.R. ...	6	10	8	7	10	13	19	24

Comments

The future use of mass radiography in general is still uncertain. It was recently estimated that there were still 50,000 undiagnosed cases of pulmonary tuberculosis in persons over the age of 15 years in England and Wales. The same report showed that 10 per cent. of the cases of lung cancer throughout the country were diagnosed with the help of mass radiography units but in just over half of these, the cases were referred by medical practitioners to static units. Both diseases when discovered by mass radiography are more often found in persons who have not had a previous chest X-ray examination.

This is borne out in our own figures here in Carlisle. The high pick-up rate both in tuberculosis and lung cancer in the Static Unit is to be specially noted. For the first time in the East Cumberland area the number of new cases of neoplasm discovered has exceeded the number of new cases of pulmonary tuberculosis discovered. Of the new cases of pulmonary tuberculosis discovered far too high a proportion are still found to have extensive disease and a positive sputum.

Of other diseases discovered by mass radiography, more of these are undoubtedly discovered amongst cases referred to a static unit by general practitioners than amongst those examined at routine surveys by the mobile unit, e.g., the vast majority of inflammatory lesions discovered came to the Static Unit. There is a steady pick-up rate in bronchiectasis and cardiac conditions throughout the whole area. Most of the cases of pneumoconiosis are naturally discovered in the western area.

We should, therefore, as far as possible, continue to concentrate on those members of the general public who have so far not had a chest X-ray. With this object in view we propose to carry out further street by street surveys in selected areas each year. During 1962 such a survey will be carried out in the City of Carlisle and another in Whitehaven. In view of the excellent results from the Static Unit we also proposed to use the Mobile Unit as a Static Unit in Whitehaven to operate every Friday from the 4th

May, 1962. In addition we are increasing the number of sessions at the Static Unit in Carlisle from two sessions a week to six sessions a week, the latter to include one evening session.

We shall also continue to try to secure the passage through the Unit of all those people whose work involves contact with large numbers of fellow-workers. The male population over the age of 45 remains as before the population group at greatest risk and we feel that street by street sessions will be advantageous where these older age groups are concerned. The recent discovery of five cases of active tuberculosis in immigrants in the East Cumberland area who were all employed in the catering industry and the high incidence over the past ten years of tuberculosis in this industry points to an occupational group which appears to necessitate closer mass radiography supervision than the general public.

There is no doubt that mass radiography still plays a very vital role in discovering a significant number of new cases of both pulmonary tuberculosis and cancer of the lung and we have not yet reached the stage when some economy in our efforts can be made. It is hoped that the provision of further static mass radiography facilities at both Carlisle and Whitehaven will be found helpful to the general practitioners in the area.

Acknowledgements

It is a pleasure to acknowledge once more the valuable help received in arranging these surveys from the Medical Officers of Health concerned in the area and from the Managements and Workers' Organisations in the factories visited.

It gives me great pleasure to acknowledge the great help and co-operation we have received from the general practitioners in the East Cumberland area. They have taken full advantage of the sessions of the Static Unit with considerable benefit to the patients concerned.

The interpretation of films and disposal of abnormalities is no easy task and would be impossible without the friendly co-operation of my colleagues on the hospital staff, and to all I tender my sincere thanks.

I would also like to thank the numerous organisations who have in any way helped us, including the Police who continue to advise with regard to the traffic problems inherent in our surveys.

APPENDIX IV

County Council Clinics

Centre	Address	Clinic Services
Alston	Cottage Hospital Alston	Ante-natal, Child Welfare, Dental, School Clinic
Aspatria	North Road, Aspatria	Ante-natal, Child Welfare, Dental, School Clinic, Speech Therapy, Welfare Foods, Orthopaedic
Brampton	Union Lane, Brampton	Child Welfare, Chiropody, Dental, School Clinic
Carlisle	14 Portland Sq., Carlisle	Child Welfare, Child Guidance, Dental, Immunisation and Vaccination, Orthoptic, School Clinic, Speech Therapy, E.N.T., Ophthalmic, Orthopaedic
Cleator Moor	Jacktrees Road, Cleator Moor	Ante-natal, Child Welfare, Dental, School Clinic, Orthopaedic
Cockermouth	Harford House, Cockermouth	Ante-natal, Child Welfare, Chiropody, Dental, Immunisation and Vaccination, School Clinic, Orthopaedic. Speech Therapy
Egremont	St. Bridget's Lane, Egremont	Ante-natal, Child Welfare, Chiropody, Dental, Hearing Therapy, School Clinic, Chest, Orthopaedic, Speech Therapy
Frizington	Council Chambers, Frizington	Ante-natal, Child Welfare, Dental, School Clinic
Houghton	Village Hall, Houghton	Child Welfare
Keswick	13-15 Bank St., Keswick	Child Welfare, Dental, Immunisation and Vaccination, Speech Therapy, Ophthalmic, Orthopaedic
Maryport	24 Selby Ter., Maryport	Ante-natal, Child Welfare, Child Guidance, Dental, Immunisation and Vaccination, School Clinic, Speech Therapy, Orthopaedic
Millom	18 St. George's Road, Millom	Ante-natal, Child Welfare, Child Guidance, Dental, Immunisation and Vaccination, School Clinic, Speech Therapy, Surgical, Chest, Gynaecological, Medical, Minor Ailments (G.P's.), Ophthalmic, Orthopaedic
Nenthead	Overwater, Nenthead	Child Welfare, School Clinic

Centre	Address	Clinic Services
Penrith ...	Brunswick Sq., Penrith ...	Ante-natal, Child Welfare, Dental, Orthoptic, School Clinic, Speech Therapy, Family Planning, Orthopaedic, Psychiatric.
Seascale ...	St. Cuthbert's Church Hall, Seascale ...	Ante-natal, Child Welfare, Immunisation and Vaccination
Seaton ...	Miners' Welfare Hall, Seaton ...	Child Welfare
Whitehaven—		
Flatt Walks ...	Flatt Walks, Whitehaven ...	Ante-natal, Child Welfare, Child Guidance, Chiropody, Dental, Hearing Therapy, Immunisation and Vaccination, Orthoptic, School Clinic, Speech Therapy, Chest, E.N.T., Ophthalmic, Orthopaedic
Mirehouse ...	Dent Road, Mirehouse, Whitehaven ...	Ante-natal, Child Welfare, Dental, School Clinic
Woodhouse ...	Woodhouse, Whitehaven ...	Ante-natal, Child Welfare, Immunisation and Vaccination. School Clinic
Wigton ...	Birdcage Walk, Wigton ...	Child Welfare, Chiropody, Dental. Hearing Therapy, Immunisation and Vaccination, School Clinic, Speech Therapy. Orthopaedic
Workington—		
Park Lane ...	Park Lane, Workington ...	Ante-natal, Child Welfare. Child Guidance, Chiropody, Dental. Hearing Therapy, Immunisation and Vaccination. Orthoptic. School Clinic, Speech Therapy. Family Planning, Orthopaedic. **Note** — Spastic Therapy Clinics held about three times a year
Harrington ...	Methodist Hall, Harrington. Workington ...	Ante-natal. Child Welfare
Westfield ...	St. Mary's Parish Hall, Moss Bay. Workington ...	Child Welfare